Maternal and Child Health Services Title V Block Grant

Marshall Islands

FY 2022 Application/ FY 2020 Annual Report

Created on 9/10/2021 at 9:40 AM

Table of Contents

I. General Requirements

I.A. Letter of Transmittal

I. General Requirements
I.A. Letter of Transmittal

REPUBLIC OF THE MARSHALL ISLANDS
OFFICE OF THE SECRETARY
MINISTRY OF HEALTH & HUMAN SERVICES
P.O. Box 16 ~ Majuro ~ Marshall Islands ~ 96960
Telephone No. (692) 625-5327 Ext: 2392/2388
Email:sechhs.rmi@gmail.com

August 30, 2021

HRSA Grant Application Center
ATTN: MCH Block Grant
901 Russell Avenue, Suite 450
Gaithersburg, MD 20879

Dear Madam/Sir,

On behalf of the Ministry of Health and Human Services in the Republic of the Marshall Islands (RMI), MCH program submits to your office the FY 2022 Title V Block Grant Application/ 2020 Annual Report.

The Ministry of Health is grateful for this opportunity to provide a report on activities the program was able to provide to improve health of mothers, children, adolescents, children with special and health care needs.

Thank you for your continued support to the RMI MCH program.

Sincerely,

Jack Niedenthal
Secretary of Health and Human Services

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The mission of the Maternal and Child Health Program is to promote and improve health and wellness of women, children, infants, children, children with special health care needs, adolescents, and families by providing quality preventive services. The RMI Maternal and Child Health Program manages the Title V Program, Children with Special Health Care Needs Program and the Family Planning program. The Maternal and Child Health program coordinates with other Public Health programs, SSDI, as well as international partners such as, United Nations International Children's Educational Fund (UNICEF), Early Childhood development (ECD) and United Nation's Population Fund (UNFPA), Early Hearing Detection Initiative (EHDI) with program activities.

The RMI Maternal and Child Health is awarded approximately $228,000.00 each year from the Title V Maternal and Child Health Services Block Grant. The MCH Program is among the 8 programs under the Bureau of Primary Health Care, under the Ministry of Health. The Ministry of Health and Human Services is among the 10 ministries in the RMI government.

MCH continues to collect and analyze data through the various programs under the Primary Health Care, Bureau of Oral health, Behavioral Health Services, Office if Health Planning, Policy, Preparedness and Epidemiology, and other partners such as the Public School System, and Non- governmental Organizations such as, Youth to Youth in Health (YTYIH), Marshall Islands Epidemiology Initiative (MIEPI) and Women United together in the Marshall Islands (WUTMI). MCH continues to work with members of the MCH Needs Assessment Steering Committee to assess the impact of strategies implemented towards addressing the priority needs of the populations served. Focus groups with key stakeholders and selected people from the community and interviews with medical providers, and other program managers are also conducted to gather information in assessing the needs of the MCH populations.

The changing MCH population demographics, emerging health trends and shifting of program capacity require that the MCH program routinely engage in assessing the needs of the MCH population in RMI. In 2020, the MCH program in collaboration with MIEPI and key stakeholders completed a 5-year comprehensive needs assessment in which we examined areas of priority and alignment between local MCH priority needs and the national Title V National Outcome Measures (NOMs) and National Performance Measures (NPMs). The process resulted in the selection of NPMs in each of the five population health domains for programmatic focus over the 5-year cycle and development of State Performance Measures (SPMs) for priorities not addressed by NPMs.

Priorities and Performance Measures Linkage

Priority	Performance Measures
Women and Maternal	
Improve women/maternal health through cancer screening, prenatal and family planning services	NPM 1 Percent of women ages 18 thru 44 with a preventive medical visit in the past
	SPM 4 Percent of women ages 25-49 years old screened for cervical cancer
	SPM 6 Percent of women ages 15-44 years old who use Family planning services
Perinatal/Infant Health	
Improve perinatal/infant's health through	NPM 4 - A) Percent of infants who are

adequate quality prenatal services and newborn screening	ever breastfed B) Percent of infants breastfed exclusively through 6 months
	SPM 7 Percent of newborns that received the Congenital Hypothyroidism newborn screening
	SPM 8 Percent of newborn that received CMV screening.
	SPM 9 Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy
Child Health	
Parent-completed developmental screening tools	NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parentcompleted screening tool
	SPM 3 Increase percentage of fully immunized children ages 19-35
	NPM 7.1: Rate of hospitalizations for non-fatal injury per 1000,000 children ages 0-9.
Adolescent Health	
Improve adolescent health through promotion of adolescent well being and reducing teen pregnancy	NPM 10 Percent of adolescents ages 12 through 17 with a preventive medical visit in the past year.
	SPM 5 Increase use of family planning services to teenagers ages 13-17 years old
CSHCN	
Improve enrollment and special care of CSHCN through developmental screening and referral's to proper care	NPM 12 Percent of adolescent with and without special health care needs, ages 12 through 17 , who received services necessary to make transition to adult care.

MCH program utilizes MCH block grant funds to support and provide comprehensive, coordinated and family-centered services, including services for children with special healthcare needs, by providing enabling services (clinic outreach, community awareness, family support services, case management/coordination and transportation to and from Majuro, Ebeye and the outer islands for case management and referral to Shriners for surgery). These activities are coordinated through partnerships with local programs across systems that serve the MCH populations. Partners include Youth to youth in health, Women United together in the Marshall Islands, Ministry of Internal Affairs, Public School System and other non-profit and/or non-governmental organizations. These partnerships are critical in the MCH Bureau's efforts in expanding its reach for serving target groups and for integrating services to support a comprehensive system of care for the women, children, and their families.

The information submitted in the Marshall Islands Title V Block Grant Annual Report/Application reflects the efforts over the past year in implementing strategies identified in the State Action Plan to address RMI MCH Priorities across the five health domains: Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, and Children with Special Healthcare Needs. The following is a summary of accomplishments during 2020, challenges, and plans for the 2022.

Maternal/Women Health

Priority: Improve women /maternal health through cancer screening, prenatal and family planning ser vices.

Women/ Maternal Health

Priority: Improve women/maternal health through cancer screening, prenatal and family planning services.

Highlights:
-Increase in the number of atolls visited, number visited was 8
-Continue partnership with Cancer program in patient navigation, clinics are extended extra hours for women to access services.
-Awareness in the communities and faith-based organization
-Family planning after dark clinic ongoing.
-Training on commodity supply management completed, training by UNFPA.
-Dental outreach visits to OI

Challenges:
-Lack of knowledge on the importance of annual checkups, women tend to come to the clinic only when there's problem.
-Database for cervical cancer screening not working.

Plan:
-To expand services to the communities, have cervical cancer screening at the health centers on Majuro and OI.
-Order HPV DNA test kit, this is a self-collect kit which is very convenient and will increase number of women screened.
-MCH one stop shop- where all MCH services will be available.

Perinatal/Infant Health

Priority: Improve perinatal/infant's health through adequate and quality prenatal services and newborn screening

Highlights:
-Counselling on importance of exclusive BF are offered to all pregnant women on their first visit to the hospital. Such counselling is also offered at the Maternity ward and at the postnatal clinic with all mothers. 100% of all newborns ever breastfed.
-Radio awareness and spots on importance of early prenatal visits.
-Discount fee of 25% for women who attend prenatal by first trimester visit.

Challenge:
-Newborn screening was not implemented, due to lab capacity and unavailability of testing kits.
-Low % of women coming in during first trimester

Plan:

-Provide refresher training on BF to health workers.
-Coordinate with lab and pediatrician for the development of guidelines for CMV and Congenital Hypothyroidism screening and treatment.
-To extend the first trimester visit to 2nd trimester

Child Health

Priority: Improve child health through early childhood developmental screening and vaccinations/Promote child safety in the community.

Highlights:
-Developmental tool standardized and in use.
-Passport created in local language, pending printing for distribution.
-Clinics open on Saturdays for immunization appointment.

Challenges:
-Program was not able to work with PSS on child safety policies and awareness education, due to COVID activities.

Plan:
-Program will coordinate with Red cross for First Aid awareness in the schools and communities.
-Continue with immunization trips and outreach on Majuro and OI .

Adolescent Health:

Priority: Improve adolescent health through promotion of adolescent wellbeing and reducing teen pregnancy

Highlights:
-Increase on number of 13-17 years old who access family planning services.
-Community awareness conducted to NGO groups and youth group.
-FP training in Sept 2021
-HPV vaccinations in schools.

Challenge:
-Myths associated with the FP commodities.
-Stock out of commodities
- No parent consent on Family planning services at the public high school.

Plan:
-Increase awareness at schools and in the communities.
-Advocate for parents consent during PTA meetings.
-Include Sexual and Reproductive Health in school curriculum.

CSHCN

Priority: Improve enrollment and special care of CSHCN through developmental screening and referrals to proper care.

Highlights:
-Referrals from MCH clinic to Human Services for evaluation.
-Parents and Doctor sessions

Challenges:
Pending guidelines and registry due to the COVID activities.

Plan:
Coordinate with pediatrician and Psychiatrist for development of guidelines

Coordinate with SSDI coordinator for the development of the Registry.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

MCH Block Grant funds are used to support the overall MCH efforts in the Marshall Islands. Primarily, Block Grant funds support Enabling Services to improve and increase access to health care and improve health outcomes of the RMI MCH population. The types of enabling services supported include care and referral service Coordination for Children of Special Healthcare Needs and families, Laboratory Supplies for Cervical cancer screening, NCD screening, STI screening, pregnancy test kits, Pap kits, Health Education and Counseling for Individuals, Children, and Families, Outreach visits to the outer islands, and Referrals. MCH Block grant also supports public health services and system. Supporting activities and infrastructure to carry out core public health functions in RMI is critical for the efforts being made towards improving population health. Specifically, MCH Block Grant funds are used to support staff positions for MCH and CSHCN program managers, dental assistant, and nurses to provide quality services
to the population. Funds also support annual and five-year needs assessment activities alongside with SSDI, education and awareness campaigns, program development implementation and evaluation. Funds are also used to support workforce development towards building capacity among MCHB staff, nurses, and other health workers who provide services to the MCH population.

III.A.3. MCH Success Story

MCH program collaborated with Ministry of Culture and Internal Affairs in the development and implementation of Disability Identification Card for persons (children and adult) with disabilities. The purpose of this project is to persons with disabilities to have the right to special allowances, benefits, and services in addition to other forms of social protection schemes available to the general population. The program is starting off with wheelchair bound children, cerebral palsy and will include other disabilities.

Within this Act on the Section 106. Benefits and Privileges of Children with disabilities-Government (1) The Government shall provide, at the minimum, twenty-five percent
(25%) discount per month to the persons with disabilities for the following:

- On medication and other essential supplies, accessories and equipment purchased from the Ministry of Health and Human Services.
- On medical and dental services provided by the Ministry of Health and Human Services
- On the total cost of a ticket from Air Marshall Islands, provided the tickets is in the name of the persons with disability to be personally used by him/her.
- On actual transportation fare for domestic sea and shipping vessels, with free freight of 50 lbs.

2020 is a hard year for everyone. RMI close its borders since March 2020 which affected the medical referral including the children with special health care needs. But despite the pandemic and the travel restriction, MCH Program and Medical Referral Services were able to refer 2 children who needed immediate surgical procedures to Shriner's hospital in Honolulu. These children underwent surgery and physical therapy successfully. Children with their family escorts have returned home experienced the 28 days of quarantine set by the Government of RMI

III.B. Overview of the State

Overview of the State – Republic of the Marshall Islands

As a grantee of the Maternal and Child Health Services Title V Block Grant Program, the Republic of the Marshall Islands (RMI) is required to do a statewide maternal and child health (MCH) needs assessment every five years. The needs assessment process outcome is the identification of priority needs for the maternal and child population groups.

The RMI Ministry of Health and Human Services' (MOHHS – formerly known as Ministry of Health) MCH Program is responsible to facilitate the needs assessment process and administers MCH grant funds. The mission statement of the Ministry is "To provide high quality, effective, affordable, and efficient health services to all people of the Marshall Islands, through a primary care program to improve the health statistics, and build the capacity of each community, family and the individual to care for their own health". To the maximum extent possible, the MOHHS pursues these goals using the national facilities, staff and resources of the RMI.

Geography

The Marshall Islands are located in the Central Pacific Ocean, approximately 2,000 miles southwest of Hawaii and 1,300 miles southeast of Guam. They are comprised of 29 scattered chains of remote atolls, the Eastern Ratak (Sunrise) and Western Ralik (Sunset). The total land area is 181 square kilometers and has some 370 km of coastline (less than 0.01 percent of the total surface area). The Marshall Islands face great challenges in the delivery of basic health services. Transportation and communications are limited by the isolated nature of many of the islands and atolls. Two-thirds of the population lives on the two major urban atolls, Majuro and Kwajalein (including Ebeye Island). Population densities in some of the urban settlements exceed 28, 000 people/km^2. More than half of the RMI total population lives in Majuro. The Marshallese is of Micronesian origin. The matrilineal Marshallese culture revolves around a complex system of clans and lineages tied to land ownership. The Marshall Islands has an area of 1826 square kilometers and is composed of two coral atoll chains in the Central Pacific.

Figure 1 Map of the Republic of the Marshall Islands

The Marshall Islands is a parliamentary democracy, constitutionally in free association with the United States of America. It has a developing fisheries and service-oriented economy. It is mainly a Christian nation with the majority of the population being protestant followed by Catholic and other religions. The two main urban centers (Majuro and Ebeye-Kwajelein atoll) have paved roads and with piped water and a sewer system. The island of Ebeye is considered to be one of the most densely populated places in the world, only second to Bangladesh/Dakka. While the majority of the RMI population is concentrated on the two main urban centers, it is important to note that a great portion is dispersed around the many islands/atolls. This makes the provision of comprehensive health services to the entire population a challenge. However, the development of fundamental services such as health care and education has, over many decades, developed and improved in the remote

islands. Health services capacity is further enhanced through provision of on-site health visits and follow-up care from the urban centers through field trips including availability of case evacuation and referrals to the central hospital. This established system is under RMI constitutional mandate, a responsibility of the Government.

Population

The total population count of the 2011 census is 53,158; which increased only by 2,300 people since the last census in 1999. The slow growth of the population in the country is primarily caused by the emigration of the Marshallese to the United States and elsewhere. (UNFPA, 2014) The population for 2019 is . The Marshall Islands has a young population. 66% of RMI Population is less than 30 years old.

In FY2020, the MCH Program has served the following population:
1. Pregnant Women : 1,631
2. Infant <1 year old : 1,028
3. Children from 1 to 22 years old: 3,588
4. CSHCN : 89
5 Others: 2,668

Population Demographics

The population of the RMI is 53,158 persons (2011 Census), with Majuro and Kwajalein (largely Ebeye) currently accounting for three-quarters of the country's population (Table 1). The RMI population growth rate was a mere 0.4% over the past twelve years. However, the United Nations Development Programme (UNDP) estimates RMI's true population growth rate as 2.2%, one of the highest in the Pacific region. Furthermore, the average annual growth rate in the outer atolls and islands -1%, depicting a rural to urban migration, with overseas destinations assuming greater importance as well.

Table 1. RMI Population Size, Growth Rate and Density for Majuro, Kwajalein and Outer islands

Atoll /Island	Population				Average Annual Growth Rate			Land area sq./ miles	Population Densi		
	1980	1989	1999	2011	1980-1988	1988-1999	1999-2011		1988	1999	201
TOTAL (RMI)	**30,873**	**43,380**	**50,840**	**53,158**	**4.2**	**1.5**	**0.4**	**70.1**	**619**	**726**	**75**
Majuro	11,791	19,664	23,676	**27,797**	6.3	1.8	1.4	3.8	5,244	6,314	**7,4**
Kwajalein	6,624	9,311	10,902	**11,408**	4.2	1.5	0.4	6.3	1471	1,722	**1,8**
Other outer atolls & islands*	12,458	14,405	16,262	**13,953**	2	1	-1	55.3	395	419	**33**

*the remaining 32 outer atolls and islands and EPPSO-classified as 'Rural RMI'

Source: RMI Census on Population and Housing 2011, EPPSO

The total population count of the 2011 census is 53,158; which increased only by 2,300 people since the last census in 1999. The slow growth of the population in the country is primarily caused by the emigration of the Marshallese to the United States and elsewhere. (UNFPA, 2014)

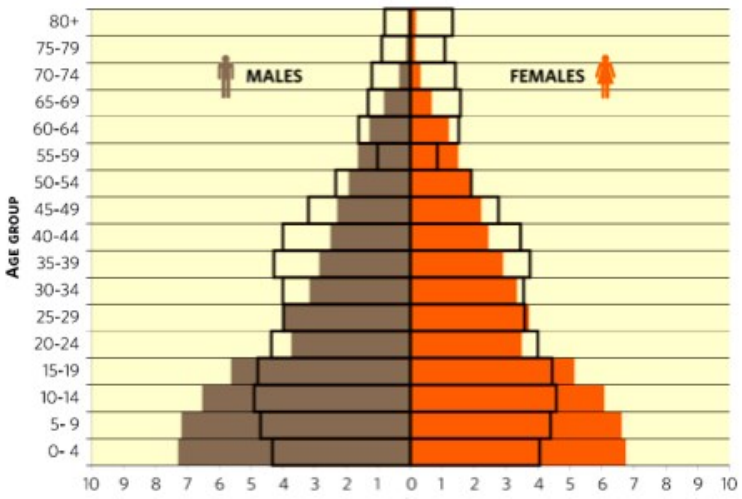


Figure 2 Population in RMI by age and sex: 2015 (shaded area) and 2050 (outlined)

While the majority of the RMI population is concentrated on the two main urban centers, it is important to note that a great portion is dispersed around the many islands/atolls. The last RMI Census was in 2011 with the next census planned for in 2021. The projected population growth predicts a slow but steady rise for the RMI, with more rural (outer islands) to urban (Majuro/Kwajalein) migration.

Table 2. Projected RMI Population by Atoll, 2020-2025

Atoll	RMI Census 2011	Projected Population					
		2020	2021	2022	2023	2024	2025
Total	**53,931**	**54,897**	**55,090**	**55,283**	**55,476**	**55,669**	**55,862**
Ailinglaplap	1,652	1,557	1,537	1,518	1,499	1,480	1,461
Ailuk	281	209	194	180	165	151	136
Arno	1,702	1,588	1,565	1,542	1,519	1,496	1,473
Aur	486	471	467	464	461	458	455
Bikini	8	6	6	5	5	5	4
Ebon	641	559	543	526	510	494	477
Enewetak	601	522	507	491	475	459	444
Jabat	80	76	75	74	73	72	71
Jaluit	1,828	1,877	1,887	1,897	1,907	1,917	1,927
Kili	473	379	360	341	322	303	284
Kwajalein	11,577	11,788	11,830	11,872	11,914	11,956	11,998
Lae	355	366	368	370	372	374	376
Lib	158	161	162	162	163	164	164
Likiep	359	307	296	286	275	265	254
Majuro	29,171	30,888	31,231	31,575	31,918	32,261	32,605
Maloelap	624	552	537	523	508	494	479
Mejit	325	297	291	286	280	274	269
Mili	640	518	493	469	444	420	395
Namdrik	420	310	288	266	244	222	200
Namu	739	688	678	667	657	647	637
Rongelap	99	124	129	134	139	144	149
Ujae	339	307	301	294	288	282	275
Ujelang	0	0	0	0	0	0	0
Utirik	436	437	437	437	437	437	437
Wotho	81	61	57	53	49	45	41
Wotje	857	854	853	853	852	851	851

Source: Economic Policy, Planning and Statistics Office, 2020

Table 3. Projected RMI Male Population by Age, 2020-2025

	RMI Census 2011	Projected Male Population					
		2020	2021	2022	2023	2024	2025
Male	**27243**	**28,134**	**28,233**	**28,332**	**28,431**	**28,530**	**28,629**
0 - 4 years	4031	4,163	4,177	4,192	4,207	4,221	4,236
5 - 9 years	3622	3,740	3,754	3,767	3,780	3,793	3,806
10 - 14 years	3385	3,496	3,508	3,520	3,533	3,545	3,557
15 - 19 years	2417	2,496	2,505	2,514	2,522	2,531	2,540
20 - 24 years	2614	2,699	2,709	2,718	2,728	2,737	2,747
25 - 29 years	2159	2,230	2,237	2,245	2,253	2,261	2,269
30 - 34 years	1876	1,937	1,944	1,951	1,958	1,965	1,971
35 - 39 years	1587	1,639	1,645	1,650	1,656	1,662	1,668
40 - 44 years	1419	1,465	1,471	1,476	1,481	1,486	1,491
45 - 49 years	1189	1,228	1,232	1,237	1,241	1,245	1,249
50 - 54 years	1016	1,049	1,053	1,057	1,060	1,064	1,068
55 - 59 years	815	842	845	848	851	854	856
60 - 64 years	583	602	604	606	608	611	613
65+ years	346	547	549	551	553	555	557

Table 4. Projected RMI Female Population by Age, 2020-2025

	RMI Census 2011	Projected Female Population					
		2020	2021	2022	2023	2024	2025
Female	**25915**	**26,763**	**26,857**	**26,951**	**27,045**	**27,139**	**27,233**
0 - 4 years	3712	3,833	3,847	3,860	3,874	3,887	3,901
5 - 9 years	3395	3,506	3,518	3,531	3,543	3,555	3,568
10 - 14 years	3108	3,210	3,221	3,232	3,244	3,255	3,266
15 - 19 years	2314	2,390	2,398	2,406	2,415	2,423	2,432
20 - 24 years	2480	2,561	2,570	2,579	2,588	2,597	2,606
25 - 29 years	2245	2,318	2,327	2,335	2,343	2,351	2,359
30 - 34 years	1913	1,976	1,983	1,989	1,996	2,003	2,010
35 - 39 years	1549	1,600	1,605	1,611	1,617	1,622	1,628
40 - 44 years	1366	1,411	1,416	1,421	1,426	1,431	1,435
45 - 49 years	1155	1,193	1,197	1,201	1,205	1,210	1,214
50 - 54 years	914	944	947	951	954	957	960
55 - 59 years	761	786	789	791	794	797	800
60 - 64 years	469	484	486	488	489	491	493
65+ years	534	551	553	555	557	559	561

Educational Attainment

The level of educational attainment is an important indicator of the degree of development and quality of life standards achieved by countries, as reflected in many demonstrated inter-relationships between education and demographic, economic and social development. For example, educated mothers tend to have fewer and healthier children. Higher levels of education also contribute to a better qualified workforce, and better educated people also have improved chances to find employment, both domestically and overseas. It is for such reasons that education is an important development goal for Pacific island countries and their development partners.

According to the RMI 2011 Census, 42.9% of people aged 25 and over have completed high school or pursued further studies and training; an additional 47.8 % had completed primary education (19.2%) or completed some years of High school (28.6%). While this picture represents a small improvement over the situation prevailing in the late 1990s, as reflected in comparative figures of 40.1% and 45.6% respectively, the fact that (1) 28.6% of people aged 25 or older had started but not completed high school, and that (2) this proportion actually increased since the late 1990s (21.6%), could be seen as two major policy challenges.

The vast majority of Marshallese attends school, although many do not complete primary school and very few go on

to complete secondary or higher education. Starting at age 14, attendance rates decline noticeably for all children.

Educational Attainment in the RMI, 1999 and 2011 comparison

Educational Attainment	1999		2011	
	Number	Percent	Number	Percent
No Schooling	554	3.1%	296	1.3%
Some Elementary	2003	11.2%	1747	7.9%
Elementary completed	4284	24.0%	4247	19.2%
Some high school	3858	21.6%	6317	28.6%
High School completed	4450	24.9%	5478	24.8%
Some college or higher	1419	7.9%	2008	9.1%
College or higher completed	1303	7.3%	1987	9.0%
Total	17871	100.0	22080	100.0%
Source: RMI Household Census 2011				

Enrollment Status

School enrollment has increased slightly for children aged 5-9 years to 80.1% in 2011 from 74.2% in the late 1990s, and increased to 91.9% from 86.6% aged 10-14 over the same period. While showing a positive development in recent years, building on these achievements in the context of achieving education for all children, especially those that drop out due to adolescent pregnancy and reversing the recent decline in enrollment represent an important policy challenge

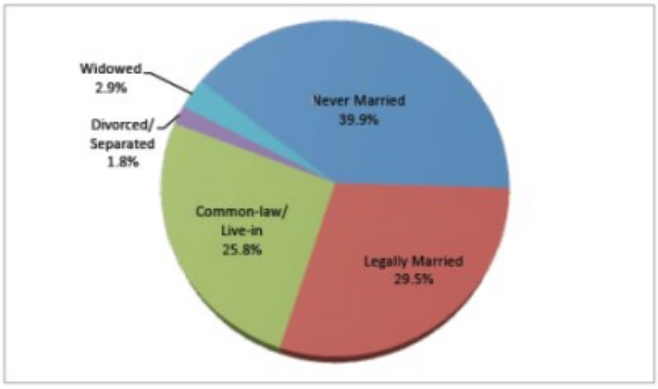
Enrollment Ratios by Age Group, 5-24, 1999 and 2011

Age Enrolled	Number Enrolled		Total Persons		Enrollment Ratio	
	1999	2011	1999	2011	1999	2011
5 - 9	4,929	5,611	6,640	7,009	74.2%	80.1%
10 - 14	6,518	5,943	7,513	6,464	86.8%	91.9%
15 - 24	**4,719**	**3,601**	**10,861**	**9,473**	**43.4%**	**38.0%**

Nuptiality

Figure 3 shows the distribution of household population 12 years old and over by marital status. More than half of this population (55.4%) was married, with 29.5 percent legally married and 25.8 percent living in a common-law union or live-in status. Almost two-fifths were never married and some 3 percent were widowed and 1.8 percent were either divorced or separated. Over three-quarters of widowed persons were women; this is attributed to the difference in the age of spouses at the time of marriage (women tended to be younger than their spouses) and a higher life expectancy at birth for women compared to men. The percentage of widowed women increased with age as they tended to remarry less frequently upon divorce or the death of a spouse.

Figure 3 Population 12 years old and over by marital status, RMI: 2011



In every age group, a higher percentage of males were never married than females, supporting the general observation that men marry later than women. In the 15–19 age group, over 95 percent of males and 88.9 percent of females in the Marshall Islands were never married. The percentage of the never married population declined significantly with age. In the 40–44 age group, less than 10 percent of males and females were never married.

Health care in the RMI

In 1986 the RMI Government adopted the concept of Primary Health Care declared by the WHO in 1978. The Bureau of Primary Health Care was established to target the strengthening of preventive programs/services at the community level. The bureau is renamed the Bureau of Primary Health Care Services.

The health care system comprises two hospitals, one in Majuro and one in Ebeye and fifty-six (56) active health care centers in the outer atolls and islands. Both hospitals provide primary and secondary care, but limited tertiary care. Patients who need tertiary care are referred to Honolulu, ROC-Taiwan, or the Philippines.

Health centers in the outer islands focus on the preventative, promotive and essential clinical care services. All health care centers are permanently staffed by full time Health Assistants who provide health services. Currently, there are 16 Health Assistant Interns on training provided by our Marshallese Doctor. They are following a curriculum designed by Fiji National University and PIHOA. They will replace the retired Health Assistants.

Table 4 indicates the hospital and health centers under the MOHSS. Leroij Atama Zedkeia Medical Center commonly known as Majuro Hospital and Leroij Kitlang Memorial Health Center commonly known as Ebeye Hospital are serving inpatient, outpatient, public health clinics and ancillary services. There are 56 Health Centers in RMI. 177 Health Care Program funded by US grant can hire 1 doctor and 1 health assistant in their 4 Outer Islands Clinics namely Utrik, Enewetak, Kili and Mejatto. 177 Health Care Program provide services to the people that were affected by the nuclear testing. Aside from the 177 Health Centers, Health Assistants are the health care providers in the health centers. Medical and public health staff conduct outreach services to the health centers in the outer islands. Health centers in the Outer Islands provides preventative, promotive and essential clinical care services. If the services in the Outer Islands are not enough, the patients are referred to the 2 main hospitals via regular referral or medical evacuation.

Table 5: Health Care Locations			
MAJURO ATOLL			
• Leroij Atama Zedkeia Medical Center (Majuro Hospital) • Laura Health Center • Rongrong Health Center • Woja Health Center			
KWAJALEIN ATOLL			
• Leroij Kitlang Memorial Health Center (Ebeye Hospital) • Santo Dispensary • Ebadon Dispensary • Gugeegue Dispensary			
OUTER ISLANDS HEALTH CENTERS			
Ratak Chain 1. Aerok 2. Maleolap 3. Ailuk 4. Arno 5. Aur 6. Bikarej 7. Enejelar 8. Enejit 9. Ine 10. Jang 11. Jebal 12. Kaven 13. Kilange 14. Likiep	15. Lukonwor 16. Mejit 17. Milli 18. Nallu 19. Ollet 20. Tarawa 21. Tinak 22. Tobal 23. Tokewa 24. Tutu 25. Ulien 26. Wodmej 27. Wotje	**Ralik Chain** 1. Aerok Ailinglaplap 2. Bwoj 3. Ebon 4. Imiej 5. Imiroj 6. Jabnoden 7. Jabot 8. Jabwor 9. Jaluit 10. Lae 11. Lib	12. Loen 13. Mae 14. Majkin 15. Mejrirok 16. Namdrik 17. namu 18. Narmij 19. Toka 20. Ujae 21. Woja 22. Wotho
177 HCP Program	Department of Energy Clinic	Kumit Wellness Center	Taiwan Health Center
Majuro Clinic Ejit Clinic Kili Heakth Center Enewetak Health Center Utrik Health Center Mejatto Health Center			

Table 6: No. of Beds in the two Main Hospitals	
Hospital	No. of beds
Leroij Atama Zedkeia Medical Center (Majuro Hospital)	101
Leroij Kitlang Memorial Health Center (Ebeye Hospital)	54

Table 7: Private Clinics and Pharmacy	
Clinic Name	Location
Majuro Clinic	Delap, Majuro
Eyesight, Professional	Delap, Majuro
Medisource Pacific Pharmacy	Majuro and Ebeye

Top 10 Causes of Death- RMI, 2020

FY2020		
Rank	**Underlying Cause of Death**	**Count**
1	Cardiovascular Diseases	95
2	Diabetes Related	53
3	Pneumonia	41
4	Cancer	36
5	Sepsis	15
6	Suicide	12
7	Drowning	10
8	Perinatal Conditions	9
9	Gastroenteritis	6
10	Chronic obstructive pulmonary disease/ Gastrointestinal bleeding	5

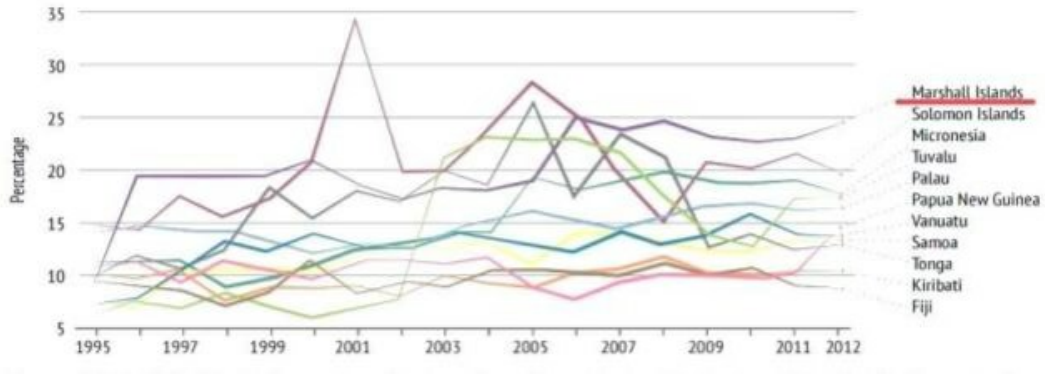
Top FY2020 Majuro Hospital Outpatient Diagnosis			
1	Z23	Encounter for immunization	3482
2	Z34	Encounter for supervision of normal pregnancy	2655
3	J00-J06	Acute Upper Respiratory Infections	1177
4	J20	Acute bronchitis	662
5	E10-E14	Diabetes mellitus	591
6	N39.0	Urinary tract infection, site not specified	513
7	O34.21	Maternal care for scar from previous cesarean delivery	369
8	I10	Essential (primary) hypertension	344
9	M54.5	Low back pain	297
10	O09.893	Supervision of other high risk pregnancies, third trimester	225

Government health funding and human resources

In a 2015 WHO study of 11 selected Pacific Island countries, the RMI had the highest government health expenditure in the last six years of period reviewed (Figure 3) . The study found RMI government funding amounted to only 40% of the necessary health expenditure for the entire population. A considerable proportion of the remaining health budget is sourced from external aid, comprising mainly of US Compact of Free Association (COFA) payments and other US federal assistance.

Figure 3 Government health expenditures as a percentage of total government expenditures in selected Pacific Island countries, 1995-201 2

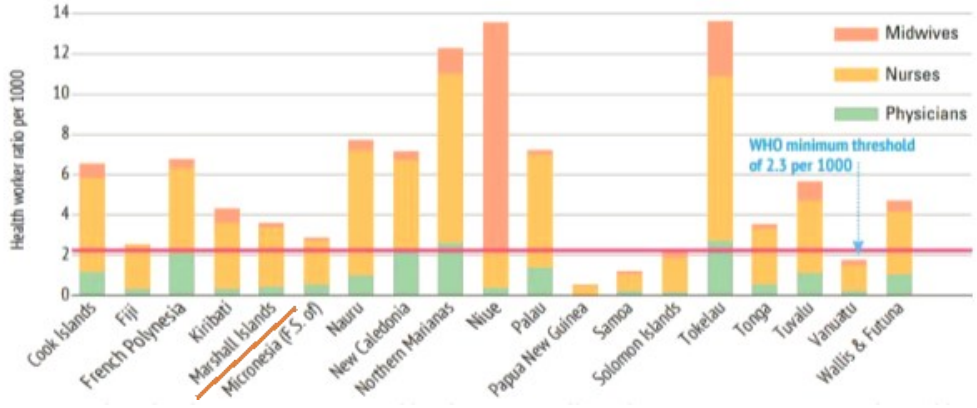
Source: World Health Organization (WHO) Global expenditure database, 2015



Furthermore, limited human resources in the RMI cause substantial strain on the health system.

Although the RMI meets the WHO minimum threshold for the health workforce (Figure 3-9), the majority of physicians are expatriate contract-workers (WHO, 2015). According to the MOH Annual Report 2015, 43 physicians were employed with the majority posted at the Majuro Hospital. To support the health system, over 66 health assistants were hired and generally serve in rural health clinics.

Figure 4 Health workforce (doctors, nurses and midwives) per 1,000 population in selected Pacific Island countries, 2015



Source: The first 20 years of the journey towards the vision of Healthy Islands in the Pacific, World Health Organization (WHO) (2015)

Communication

In 2020, Ministry of Health and Human Services and Marshall Islands National Telecommunication Authority (MINTA) partnered through a grant to install VSAT in all the health centers in the Outer Islands. This will replace the DAMA (Demand Assigned Multiple Access) Systems which have high subscription fee and expensive maintenance. The VSAT will provide voice and data. Our plan is to be able to use the VSAT services for better communication, telehealth, access to the MHIS (Marshall Health Information System) and can provide remote training. The improvement in communication will also decrease medical evacuation that can costs from 10,000 to 15,000 per case. Specialists from Majuro and Ebeye can do an assessment first based on the information that will be submitted through email and video calls.

Through World Bank COVID-19 funds, we are purchasing laptops, UPS, solar batteries, and panels that will be assigned and installed in the health centers. These laptops will complement the VSAT connection. Once this whole system is set, MCH program will conduct its telehealth for the Children with Special Health Care Needs, High risk pregnancy and follow up of cases. Weekly reporting of syndromic surveillance, birth and death occurrence will improve.

With the Health Informatics Department's communication plan, MOHHS purchased new HF radios to replace the old/nonfunctional radios. Satellite phones were also purchased for redundant communication. Funding was provided under CDC Crisis funds – COVID-19. CDC Epidemiology and Laboratory Capacity - COVID-19 supplemental funds support the communication fees to ensure communication in all the health centers are hospitals are uninterrupted.

The main challenge for communication is the high cost. Internet connection fee is very expensive in RMI. For Majuro Hospital, we pay $10,000 per month for 20mbps of connection. $600 per month in Laura Health Center and $600 for Woja Health Center to connect for internet dsl. For Ebeye Hospital, we pay $3,600 for the internet connection per month. A total of $14,800 per month for all our internet connections. International calls are $1.25 per minute. National Calls are $0.50 per minute. To use VSAT, there will be an additional cost $200/site/month for MOHHS to incur.

Transportation

Mode of transportation:

a. Majuro: Public transportation is shared taxi with minimum fee of $1.00 to maximum of $5.00. Speed boats are used to go to the small islands, 20-30 minutes ride to the nearest small islands inside Majuro.
b. Ebeye: Public transportation is a shared taxi with a minimum fee of $1.00. Speed boats are used to go to the small islands, 1 hr. ride to go to the farthest health center in Ebeye. Ebeye Hospital staff use the military plane to go to one of the islets in Ebeye to provide health care. Military base also provides military ship to bring people from Ebeye to the US Military base where Kwajalein airport is located. Marshallese working in the base is also using the ship to go to work daily.
c. Outer Islands: RMI has a government-owned ship that brings people, food, and other supplies to the Outer Islands. Within the outer islands, there are speed boats, bicycle and trucks to bigger atolls. Air Marshall Islands has two planes that service the whole RMI. But it's not reliable.

For the MCH program, we usually travel by Air Marshall Islands. One way airfare can range from $70 on the nearest island to $400 on the farthest island. There are instances that public health outreach team including MCH staff get stranded for a day or a month if the planes are not working. We also use boats to go to the Outer Islands. The trip to Enewetak is 4-5 days via boat, which is the farthest island. Enewetak is near Pohnpei. When the weather is bad or the ocean is too rough, we can't provide outreach visits to the Outer Islands.

Food Security

The Marshall Islands face multiple challenges. It has few natural resources, and imports by far exceed exports. Agricultural production is relatively small but important to the livelihood of people and the economy.

The Republic of Marshall Islands (RMI) has been severely affected by rising food and fuel costs coupled with natural disasters. The dependency on imported fuel and food has led to high inflation rates. According to the RMI Food Security Policy (FAO, 2013), the food import in RMI goes up to 80-90% depending upon Islands. The population has seen rapidly increasing levels of food and nutrition related non communicable diseases, which impact negatively on the health system, families and national economy.

The major constraints to food security in RMI are:

- Limited technical expertise in agriculture production with the Ministry of Resources and Development (MRD)
- Lack of improved agriculture and livestock production skills among growers
- Limited disease and pest control and surveillance capacity and practices in Agriculture production system
- Lack of food preservation/processing facilities, technologies and skills
- Limited awareness and knowledge on nutrition
- High vulnerability to natural disasters

Early Childhood Development Program Update:

In 2019, the World Bank launched the Multisectoral Early Childhood Development (ECD) Program with the Ministry of Health and Human Services, Ministry of Education, Sports, and Training, Ministry of Culture and Internal Affairs, and the Ministry of Finance, Banking, and Postal Services. Results from the ICHN Survey conducted by UNICEF in 2017 portrayed an alarming rate of stunting in the Marshall Islands. The ECD program is taking on the initiative to assist with the most vulnerable, pregnant mothers, and children 0-5 years of age. It is important to highlight the much-needed action within the first 1,000 days of a child's life for intervention.

Table 1: Health, nutrition, and child development outcomes

Maternal and Child Health Outcomes	
Infant mortality rate *(deaths per 1,000 live births)*⁺*(deaths per 1,000 live births)*⁺	28
Under-5 mortality rate *(deaths per 1,000 live births)*⁺	34
Maternal mortality ratio *(deaths per 100,000 live births)*⁺	92
Low birth weight (<2,500 g), *(% last born children 0-59 months*)*	11.6
Maternal and Child Nutritional Outcomes	
Underweight *(% children 0-59 months*)*	11.7
Stunting *(% children 0-59 months*)*	35.3
Wasting *(% children 0-59 months*)*	3.6
Overweight *(% children 0-59 months*)*	3.8
Underweight/Thinness (BMI<18.5 kg/m^2), % WRA*	1.8
Overweight (BMI 25.0-29.9 kg/m^2), % WRA*	72.7
Obesity (BMI >30 kg/m^2), % WRA*	45.1
Child Development Outcomes	
Percent of children age 36-59 months developmentally on track for indicated domains	
Literacy – Numeracy	55.4
Physical	92.8
Social-Emotional	72.4
Learning	87.6
ECDI Index Score*	78.9
Literacy-numeracy: Developmentally on track if at least two of the following are true: Can identify/name at least ten letters of the alphabet, Can read at least four simple, popular words, Knows the name and recognizes the symbol of all numbers from 1 to 10. *Physical*: Developmentally on track if one or both of the following is true: Can pick up a small object with two fingers, like a stick or a rock from the ground, Is not sometimes too sick to play. *Social-emotional*: Developmentally on track if at least two of the following are true: Gets along well with other children, Does not kick, bite, or hit other children, Does not get distracted easily. *Learning*: Developmentally on track if one or both of the following is true: Follows simple directions on how to do something correctly, When given something to do, is able to do it independently.	

Sources: *UNICEF Integrated Child Health and Nutrition Survey, 2017; ⁺MOHHS Key Performance Indicators Report, 2017; ⁺⁺MOHHS Annual Report, 2017; Notes: WRA: Women of reproductive age (15-49). Note: Data are subject to the usual errors associated with small sample sizes, and in the case of population data such as IMR and MMR issues associated with measurement of mortality in small populations.

Component 1 (MOHHS) aims to improve the availability and coverage of an evidence-based package of essential

RMNCHN and stimulation services for the first 1,000 days (pregnant and lactating women and children up to age 2).

Adolescent girls, women of reproductive age and children aged 2-5 years will be secondary target groups, with interventions for these populations incorporated in an opportunistic manner and/or in later stages of Project implementation. The component seeks to both strengthen the package of services provided and alleviate supply- and demand- side barriers to the use of this package of services.
The first two years of the Project will focus on alleviating key pressure points to ensure adequate coverage of a revised and evidence-based package of RMNCH-N services in the Majuro/Ebeye Hospitals. Project financing will focus on strengthening hospital and clinic-based service delivery in Majuro and Ebeye and filling short-term gaps in supply-side readiness in OI clinics. This immediate term measure is considered vital for preventing further deterioration of key health and nutrition outcomes. The component will also support a suite of TA activities to identify strategic shifts in service delivery in order to inform further scale-up beyond the initial phase.

The component has two sub-components; one aimed at strengthening stewardship and management of health administration and the other at directly strengthening service delivery. Each sub-component will have four dimensions: (a) RMNCH-N service package; (b) human resources; (c) equipment and supplies; and (d) data and information.

Implementation of SBCC activities will be financed under component 1 (MOHHS) and other components (MOCIA, MOEST, MOFBPS). While component 1 will support MOHHS in the delivery of early years-focused SBCC activities in combination with other RMNCH-N interventions, a comprehensive, cross- sectoral SBCC strategy and campaign will be developed under component 4. Sub-component 1.1 will support the development and roll-out of training, capacity building, and coaching packages required for MOHHS to effectively deliver SBCC, whereas sub-component 1.2 will finance the production of materials, roll-out and delivery of the campaign through MOHHS channels.

5. **Sub-component 1.1:** Strengthening MOHHS management and stewardship capacity to deliver essential RMNCHN services. The objective of this sub-component is to strengthen the management and stewardship capacity of MOHHS to scale up access to a package of essential RMNCH-N services. Activities/inputs to be financed include:

• **Essential RMNCH-N Service Package:** The Project will finance a suite of TA activities to define an essential RMNCH-N package, assess supply-side readiness to deliver the package and recommend strategic shifts in service delivery needed to improve coverage and utilization. While many RMNCH-N interventions are underway, there is a need for MOHHS define and deliver a basic essential package of services, strengthening areas such as: maternal nutrition counselling during ANC; infant and young child feeding promotion; routine monitoring and promotion of optimal child growth and development; identification of disability and developmental delay, birth registration, etc. The component will support an assessment to define the essential RMNCH-N package and an expanded package of activities as well as accompanying operational guidelines for the essential package. A supply-side readiness assessment, will be undertaken to identify frontline needs and gaps. A service delivery study will be undertaken and complemented by a Health Financing Systems Assessment to develop recommendations for sustainable, cost-effective delivery models and modalities in Majuro/Ebeye and the OI.

Human Resources: The Project will finance: a human resources mapping and needs assessment to develop a HR strategic plan focusing on the delivery of the essential RMNCH-N package; TA to develop a performance management system; the development of training and coaching packages as identified in the needs assessment. Two ECD Coordinators (national and international) will be placed within the MOHHS, who will not only be responsible

for managing activities under the Ministry's mandates (as discussed under component 4), but in doing so will provide specific guidance to staff in the ministry and other implementing agencies to build capacity to work on their mandate in the future. It is expected that the national ECD coordinator will be absorbed into the MOHHS payroll during the life of the project (approximately year 4).

• **Equipment, commodities, and supplies:** The Project will finance TA on forecasting, purchasing, procurement, and commodity management, as needed.

• **Data and information:** The Project will undertake a rapid assessment of the data needs of the MCH and RH programs to monitor RMNCH-N service utilization and outcomes as well as the existing HMIS. The assessment will be used to identify gaps in the existing HMIS that already benefit from support from Taiwan, China.

6. **Sub-component 1.2:** Enhancing delivery of essential RMNCH-N services. The objective of this sub-component is to scale up access to and coverage of a package of essential RMNCH-N services. This sub-component will support the following:

Essential RMNCH-N Service Package: The Project will finance support MOHHS in delivering the newly defined package (See sub-component 1.1). This includes: the production of materials, job aides, etc.; routine operational costs of service delivery, including SBCC activities, in accordance with operational guidelines. In the first 12-24 months of the Project, the focus will be on enhancing RMNCH-N delivery in Majuro/Ebeye Hospitals and Laura Clinic. Special attention will be paid to enhancing the availability of evidence-based nutrition specific interventions, which have fallen through the cracks in primary health care. Service delivery will be scaled up to other areas based on the service delivery TA produced during Year 1 (see also subcomponent 1.1).

• **Human Resources:** The Project will finance contracted service delivery providers (e.g. doctors, nurses, midwives) to support MOHHS to achieve a more optimal number, distribution, skills/skills mix, and performance of health care professionals required to effectively deliver the RMNCH-N service package. This includes: (a) surge support to Majuro/Ebeye Hospitals to fill critical human resource gaps for RMNCH-N provision; (b) additional health providers to complement and assist the Health Assistants in the OI Dispensaries in delivering RMNCH-N services; (c) a third-party provider to deliver training and coaching to boost provider skills and adherence to guidelines; and (d) design and roll-out of a transparent performance management system, including the associated management, supervision, and mentoring costs. Direct hire or contracting arrangements identified as appropriate by the service delivery TA will be used for (a) and (b). It is expected that contract providers will be absorbed into the MOHHS payroll during the life of the project. Therefore, the number and type of additional contract staff will be included in the annual work plan and budget, and jointly agreed between the Government of RMI and the WB. Counterpart financing is one option that may be considered.

Equipment, commodities and supplies: The Project will finance the procurement of small equipment (including anthropometric measurement equipment), materials, pharmaceuticals/commodities, in order to meet standards of readiness to deliver the basic essential RMNCH-N package. In the first phase, procurement will be limited to filling equipment, commodity, and supplies requirements for the Majuro/Ebeye Hospitals, Laura Clinic, and OI Dispensaries. Additional equipment/commodity/supply requirements may be identified in in the strategic mapping and the component can finance costs of upgrading OI dispensaries and/or equipping zone nurses, health outreach workers, mobile clinics, etc. to deliver the RMNCH-N service package. Investments in the immunization cold chain will be complementary to those financed under the Asian Development Bank's regional immunization TA.

• **Data and Information Technology:** The Project will finance gaps in the IT system infrastructure (hardware,

software, and training) to monitor RMNCH-N patient records and service utilization, manage stock, and assess performance. Enhancing the availability, quality, and use of data for decision-making will be necessary in order to translate the supply- and demand-side investments to improved health and nutrition outcomes. With support from Taiwan, China, efforts are underway to upgrade and modernize the HMIS. Development of innovative IT solutions to strengthen community outreach and service delivery may be considered at the midterm review. The Project will further support the development of a database and digital dashboards to make the information for decision-making readily available.

Table 1: Key Project Data

Project Data	US$ (millions)
Original Project Amount	US$13.00
Component 1 Total Budget	US$3.66
Closing Date	December 31, 2024

NP1: Well-women visit

ECD has been involved with minor works within the Majuro and Ebeye Hospital. One project specifically applies to the MCH One Stop Shop. With guidance from the team, the ECD project has met with program managers and hospital staff to discuss the structure and floor plan of this works. Documentation has been sent over to the World Bank for approval from the safeguard and financial management team. We hope to start renovating by October 2021.

NPM3: Risk Appropriate Care

The Milestone Passbook or newborn baby passports, is set to launch in November 2021 and is currently in its final stages of approval. Translation and consultations with stakeholders have taken place to ensure consensus. Various programs such as MCH, EHDI, RH, ECD, etc. have led this project and hope to pilot this for the next 2 years to capture the much needed data and to determine next steps.

NPM13: Preventative Dental Visit

The project has initiated discussion with partners from both MOHSS and PSS to roll out the dental school check up and outreach. Early 2021, discussion took place to assist with revamping the annual school dental check ups done by the MOHHS dental team. With the support from Taiwan Health Center (THC), PSS, and MOHHS, this initiative will launch in September 2021. THC was able to give a generous donation of dental kits and ECD will assist with financial support regarding travel to Ebeye for outreach at the school's there. The main challenge is lack of funding and staff for the dental program. It is important this program can continue and reach the outer islands as a required health check up to improve overall dental health in the RMI.

Challenges:

The main challenge for the ECD project is lack of staffing and financial constraints caused by the COVID-19 pandemic. With only the National Coordinator on board, it has been a challenge hiring and keeping staff in order to implement and roll out this project. Due to the COVID-19 project, the borders have been closed and have made it harder to bring in consultants, trainers, staff, and so forth. The Ministry of Health and Human Services has been in a

constant State of Emergency since August 2019, in part due to the dengue outbreak. The MOHHS has been exhausted and working tirelessly to make sure the RMI is safe and COVID-free.

III.C. Needs Assessment
FY 2022 Application/FY 2020 Annual Report Update

Identifying Priority Needs and Linking to Performance Measures

MCH Domain	NPM #	State Priority	Evidence Based/Informed Strategy Measures	State Performance Measures
Women/ Maternal Health	NPM 1	Access to coordinated, comprehensive care and services for Women before, during and after pregnancy. Cancer screening and services for Women's Health	1.1 Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year. 1.2 Number of community health centers that provide cancer screening/referrals for women 1.3 Percent of women booked for prenatal visit in first trimester. 1.4 Percent of women receiving postpartum follow-up health care services within the first four to six weeks after delivery.	SPM 1: Percent of Women ages 25-49 years old screened for cervical cancer. SPM 2: Percent of women ages 15-44 years old that use family planning services SPM 3: Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy
Perinatal/ Infant Health	NPM 3	Reduce Infant Mortality Rate	1.1 Number of birthing hospitals re-designated with updated standard operating procedures (SOP). 1.2 Percent of birthing hospitals who complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually 1.3 Percent of newborn babies issued newborn baby passports	SPM 1: Training on the updated clinical guidelines and protocols for Obstetrics and Gynecological conditions
Perinatal/ Infant Health	NPM 4	Infants breastfed exclusively through six months	4.1 Percent of women provided with in-person or telephonic breastfeeding consults/support services 4.2 Number of MCH staff	

			and community health workers attended the Certified Lactation Counselor training.	
Child Health	NPM 6	Parent-completed developmental screening tools	6.1 The number of potential high risk screens referred to early intervention.	SPM 3: Increase percentage of fully immunized children ages 19 to 35 months
Adolescent Health	NPM 10	Child Oral Health Program partnership with schools Teen reproductive health and pregnancy prevention	10.1 Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year 10.2 Percent of public middle and high schools visited to deliver pregnancy & STI prevention program	SPM 5: Increase use of Family planning services to teenagers ages 13 to 17 years old.
Children with Special Health Care Needs	NPM 12	Develop and implement clinical management, guidelines and registry for Children with Special Health Care Needs.	12.1 Percent of youths with Special Health Care Need (CSHCN) enrolled in the non-medical related programs to receive services.	SPM 2: Final and endorsed readiness assessment of RMI MOHHS to handle Autism Spectrum Disorder, Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder Program.
Cross-Cutting/ Life Course	NPM 13	Child Oral Health Program partnership with schools	13.1 Number of children ages 1-17 years receiving preventive dental care from a dentist. 13.2 Percentage of elementary schools visited by dental program	

MCH Needs Assessment Focus Group Survey

More than 40 women shared their perspectives through 8 focus groups conducted in Majuro, Marshall Islands. The focus groups were on conducted different groups of younger and older mothers, pregnant mothers, women without children and women who gave birth in the outer islands.

Focus group participants were grouped as followed:

Description	Age group
Mothers with at least 1 child ≥5-12 years	21-29 years old
	30-40 years old
Mother who gave birth to child <2 years ago.	18-26 years old
	27-40 years old
Pregnant women	18-25 years old
	26-40 years old
Women who have never given birth	26-40 years old
Women who have given birth in the outer islands	18-40 years old.

The issues, barriers and challenges that resulted from this comprehensive focus group approach included top health issues such as accessibility to services, lack of health education, service delivery issues, screening and reproductive health services, and stress of motherhood and raising children. Social issues also emerged and included poverty, mental health and substance abuse.

One strong issue voiced by throughout the groups was the need for real services and information that are useful and available and expressed the need for people and services that were pertinent to their needs. Additionally, commonalities existed between the different adult groups and the overall lack of women seeking preventative medical care as an emerging priority.

General Health Questions:
When asked to consider the status of health of women and mothers in the RMI, a strong majority of respondents articulated that status of women's health in the RMI is "fair" and "not really good". Respondents reasons included having too many children. Respondents think women are having too many children and this hinders their time to take care of themselves and prevents women from getting physical health check-up. Respondents also cited economic hardship as another factor contributing to why women's health status in the RMI is not good. One respondent explained that economic hardship prevents a woman from being able to access healthy food.

"Poor, because from my experience, there are many issues I encounter. For example, appointments that are given are 8 am, you will go at 8 am and wait for your appointment and sometimes you will leave for lunch and come back in the afternoon." -Mother, 37-Delap

"Not really good. Especially when we are in the outer island there is not enough medical staff and medical tools to help." -Mother, 40 – Outer Island Resident

Preventative Medical Check Up:
A majority of respondents claimed they had gone to the hospital for a preventative health check within the time range of the last 12 months and five years. However, further discussion of their experiences revealed that less than half actually went for in for a routine preventative health check. Only a handful went in for routine screening while healthy. The Canvasback Mission was often referenced as the time they went in for the screening. Respondents who said they had not had a routine health screening explained that they had not gone in for a routine health screening because they felt healthy and did not see the need. Respondents also mentioned the use of local medicines to keep healthy. Additionally, respondents mentioned the lack of transportation, lack of time, financial burdens, and the unavailability of services in the outers islands.

Cancer Screening and Services:
Respondents explained that although women acknowledge the importance of a cancer health screen, most women still do not get health screenings because they're terrified of the notion they might be told they're sick or have cancer.

"I am really afraid if they say I have cancer…" Mother, 40 – outer island.

Other respondents discussed confidentiality issues, feelings of shame, insecurities with body, confidentiality of medical staff and the inconvenience of the routine health screenings for women.

"Most women who live in the neighboring islands are afraid and insecure to get screened for cancer" Female, 31 Rairok

When respondents were asked if they were aware of the recommendation that women should get a pap smear once every three years, almost all respondents claimed that they were not aware of this recommendation. Confusion and lack of understanding on recommendations for when women should go in for a Pap Smear was apparent with some respondents stating every month, twice a year, or once a year.

Prenatal Care:
When asked if pregnant women in the RMI meet the recommendation of at least four (4) prenatal visits during pregnancy, respondents think that on average women do but not all women meet this requirement. Some of the reason cited to why a woman might not meet this requirement is because the outer islands don't have doctors or women residing on Majuro may be experiencing financial hardship, lack of transportation, or being physically tired.

When asked how MCH/Hospital better support pregnant women, the three most common answers provided by respondents were:

2. Hospital should do home visits with expectant and new mothers because of financial and transportation issues.
3. Hospital needs more medical staff (doctors, nurses, midwives) for expectant mother
4. Hospital needs to upgrade medical equipment and expand the reproductive health

Can the government increase the budget or put aside a certain budget for the reproductive health and maternal unit so we can upgrade our medical equipment? They need to add more space, there is no bathroom. There was this one time I went; the maintenance guy could not fix the cause they were as no budget. Fix the lights the neonatal intensive care unit… -Mother, 28 - Rairok

All health dispensaries in the outer islands should have midwives, it should be more than one in each community. -Mother, 31- Outer Island Resident

Knowledge & Experience:
More than half of mothers said they primary source for information on how to care for their child came from their mothers and grandmothers. Second most mentioned source of information came was about the importance of breastfeeding or how to breastfeed came from hospital staff such as doctors and nurses.

When asked if they were satisfied with the information received from doctors or nurse during their pregnancy or immediately after birth, slightly more women cited being dissatisfied.

"I gave birth in Honolulu yes, but here on Majuro, I was not satisfied There was no information given to me. The doctors were too busy." -Mother, 37 – Delap

Majority of respondents identified community outreach/mass awareness campaigns and educational information sessions during prenatal and well-baby appointments for better delivering of information to educate women about healthy pregnancy and raising healthy children.

Respondents consistently throughout the groups said culture barriers that may hinder or contribute to mothers and women not seeking RH service would be if it there was a male health care professional, especially if he was a relative and for both RH and MCH it would be a language barrier issues. Almost all women said there needs to be a translator available.

"When there is a male doctor, women are afraid to get him because they are shy or sometime the person is a relative", Mother, Outer Island

Family Planning and STI Questions:
In the MCH Needs Assessment Survey 2020, a majority of respondents indicated they are in fact comfortable about seeking family planning services. Most of these respondents who indicated having no issues seeking family planning services said it's a necessity to prevent unwanted and unplanned pregnancies. Some reasoned it was a confidentiality issue. They were worried about people talking and another respondent said she was afraid because she was told they might tie her tubes.

Although the assessment did not include females under 18 years of age, in a similar focus group conducted for the Prevention of Adolescent Teenage Pregnancy Study in 2013, 100% of adolescent respondents felt that reproductive health should be taught in a mandatory school based curriculum and 70% felt counseling and contraceptives needs to be available on campus.

"There are a lot of barriers (poverty, shame, fear) preventing them to go to such places (hospital/youth to youth) that have birth control or places where there can seek information…". -female youth respondent, 17, Majuro

Infant/Child Questions:
Breastfeeding campaign was cited as a strategy validate the importance of breastfeeding. Respondents also stated mothers, especially first time mothers need more support from hospital staff and family members to learn the proper skills of breastfeeding. Some respondents indicated they (and other women) stopped breastfeeding because baby refused it or their milk supply was salty. Furthermore, respondents noted that some women don't breastfeed because they work and other women don't breastfeed because they want to be tied down socially.

Services and Strategies Questions:
All respondents were asked to list their top 2 priorities to improve Women/Maternal Child Health in the RMI. These were the most frequently mentioned priorities

- Preventative Screening for women and children
- Increase knowledge and education through outreach
- Encourage Healthy lifestyle and healthy family dynamics
- Women's Center
- More services for the outer lands

All respondents were asked what the main challenges for mothers in caring for themselves and their child/children were. The top 2 responses were:

- Financial Hardship
- Time management: juggling raising children and working

In the groups with women without children, the main challenges for women accessing preventive health services were:

- Fear of bad results during preventative screening
- No time

MCH Evidence Based Strategies (ESMs)

DOMAIN: WOMEN/MATERNAL HEALTH
NPM 1: WELL-WOMAN VISIT

ESM 1.1 Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year.

Measurement Category: Category 2: Measuring quality of effort (% of reach; satisfaction)

Service Type: Middle level: enabling services

Service Recipient: Activities directed to families/children/youth

Goal: To ensure that women are receiving education on the importance of well-woman visits

Numerator: Number of MCH women (including pregnant and postpartum) program participants who have received education on the importance of a well-women/preventive health visit in the reporting year

Denominator: Number of MCH women (including pregnant and postpartum) program participants

Significance: A well women visit is a way to make sure an individual is staying health. A well-woman visit is an excellent opportunity for counseling patients about maintaining a healthy lifestyle and minimizing health risks. Components of the visit may vary depending on the patients age, risk factors, and physician preference.

ESM 1.2 Number of community health centers that provide cancer screening/referrals for women.

Measurement Category: Category 2: Measuring quality of effort (% of reach; satisfaction)

Service Type: Bottom level: public health services and systems

Service Recipient: Activities related to systems-building

Goal: Increase to 5 the number of community health centers that provide preventive medical visits for women

Numerator: Number of health centers that provide preventive medical visits for women

Denominator: Number of community health centers

Significance: Through strong collaborative efforts, family planning campaigns and health education to include outreach to outlying communities in the RMI. The program will adopt the same strategy to provide preventive medical visits to women by increasing the number of community health centers that can provide basic preventive medical services to women such as family planning services packaged to include, STI & HIV screening, breast and cervical screening, BMI and BP checks, blood and glucose checks, dental screening, and health education and counseling.

ESM 1.3 Percent of women booked for prenatal visit in first trimester.

Measurement Category: Category 2: Measuring quality of effort (% of reach; satisfaction)

Service Type: Bottom level: public health services and systems

Service Recipient: Activities directed to families/children/youth

Goal: To have a healthy pregnancy, newborn and postpartum condition of the pregnant women.

Numerator: Number of pregnant women who had at least 4 prenatal visits, with first visit in first trimester, that delivered live birth during the reporting period.

Denominator: Number of live births during the reporting period

Significance: Having a healthy pregnancy is one of the best ways to promote a healthy birth. Getting early and regular prenatal care improves the chances of a healthy pregnancy. With regular prenatal care women can: a. Reduce the risk of pregnancy complications. b.) Reduce the fetus's and infant's risk for complications. During prenatal care, the OBGYN doesn't only discuss the pregnancy but include post-partum conditions which will prepare the pregnant women.

ESM 1.4 Percent of women receiving postpartum follow-up health care services within the first four to six weeks after delivery.

Measurement Category: Category 2: Measuring quality of effort (% of reach; satisfaction)

Service Type: Bottom level: public health services and systems

Service Recipient: Activities directed to families/children/youth

Goal: Increase or maintain the percentage of women receiving postpartum follow-up health care services within the first four to six weeks after delivery.

Numerator: Number of women receiving postpartum follow-up health care services within the first four to six weeks after delivery.

Denominator: Weighted number of resident women population with a recent live birth. Denominator includes all respondents except those with missing, don’t know and refused answers.

Significance: Access to quality health care services during preconception, prenatal, postpartum and inter-conception phases for women of child bearing age is crucial for reducing adverse perinatal maternal health outcomes. The postpartum examination is a particularly important medical examination that is recommended

to occur at about 4-6 weeks after delivering a baby. The checkup typically includes discussion of any problems that may have occurred during pregnancy, physical and biometric checks for elevated blood pressure and diabetes, discussions of postpartum depression symptoms, and other concerns. Postpartum follow-up visits are critical to assess women's post-delivery health and health risks, and greatly benefit current and future maternal and newborn health.

DOMAIN: PERINATAL/INFANT HEALTH
NPM 3: RISK APPROPRIATE PERINATAL CARE

ESM 3.1 Number of birthing hospitals re-designated with updated standard operating procedures (SOP).

Measurement Category: Category 2: Measuring quality of effort (% of reach; satisfaction)

Service Type: Bottom level: public health services and systems

Service Recipient: Activities related to systems-building

Goal: Update perinatal regionalization standards and designations and implement updated performance measures for hospitals in Majuro and Ebeye.

Numerator: Number Birthing Facilities Re-designated with standard operating procedures

Denominator: Total Number Birthing Facilities in the state

Significance: It is imperative for the RMI to ensure all hospitals are functioning in accordance with current standards of care for both maternal and infant outcomes.

ESM 3.2 Percent of birthing hospitals who complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually

Measurement Category: Category 2: Measuring quality of effort (% of reach; satisfaction)

Service Type: Bottom level: public health services and systems

Service Recipient: Activities related to systems-building

Goal: To accurately identify the neonatal and maternal level of care provided at the birthing hospitals in the RMI.

Numerator: Number of birthing hospitals who complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually

Denominator: Number of hospitals in the RMI

Significance: Ensuring infants are born at facilities that are equipped to meet the need of both the infant and the mother is important to improve both maternal and neonatal outcomes. The LOCATe tool is a hospital survey on obstetric and neonatal practices and services which classifies maternal and neonatal levels of care

based on responses to survey questions.

ESM 3.3 Percent of newborn babies issued newborn baby health passbook

Measurement Category: Category 2: Measuring quality of effort (% of reach; satisfaction)

Service Type: Bottom level: public health services and systems

Service Recipient: Activities related to systems-building

Goal: To provide parents of newborn babies a passbook to monitor baby milestones, development, immunizations and clinic schedule.

Numerator: Number of newborns issued a newborn baby health passbook annually

Denominator: Number of births in the RMI per year

Significance: Ensure newborns are equipped with a tool to monitor their growth, development, immunization and clinic schedule.

NPM 4: BREASTFEEDING

ESM 4.1 Percent of women provided with in-person or telephonic breastfeeding consults/support services

Measurement Category: Category 1: measuring quantity of effort (counts and "yes/no" activities)

Service Type: Middle level: enabling services

Service Recipient: Activities directed to families/children/youth

Goal: Increase the number of infants breastfed up to six months and increased the percent of infants exclusively breastfed.

Numerator: Number of women provided with in-person or telephonic breastfeeding consults/support services

Denominator: N/A

Significance: Breastfeeding is the normative standard for infant feeding and nutrition and can result in improved infant and maternal health outcomes. Moreover, promoting and/or facilitating community activities that reinforce breastfeeding may allow for more women across the state to have access to the support they need to initiate breastfeeding and continue doing so exclusively for at least 6 months.

ESM 4.2 Number of MCH staff and community health workers attended the Certified Lactation Counselor training.

Measurement Category: Category 2: Measuring quality of effort (% of reach; satisfaction)

Service Type: Middle level: enabling services

Service Recipient: Activities directed to professionals

Goal: To increase the percent of infants who have ever been breastfed and continues until 6 months.

Numerator: Number of MCH Staff and community health workers who attended the Certified Lactation Counselor training.

Denominator: Total number of MCH Staff and community health workers.

Significance: Receiving health education prior and during pregnancy can motivate mothers to breastfeed their babies. But an on-call staff or community health outreach worker who takes calls anytime or makes home visits to assist with mom who needs counseling and coaching through a hard time can also motivate them to keep breastfeeding.

DOMAIN: CHILD HEALTH
NPM 6: DEVELOPMENTAL SCREENING

ESM 6.1 The number of potential high risk screens referred to early intervention.

Measurement Category: Category 1: measuring quantity of effort (counts and "yes/no" activities)

Service Type: Top level: direct services

Service Recipient: Activities related to systems-building

Goal: That 100% of high risk screens are referred to an early intervention program and our documented.

Numerator: Percentage of high risk screens referred to early intervention/Part C.

Denominator: N/A

Significance: Research shows that healthcare providers' knowledge of and referral patterns to early intervention services and other community services is quite low. It is important that we increase knowledge through academic detailing and other onsite outreach efforts. Specific attention will focus on ensuring that children identified at risk for developmental delays following a screen are actually linked with and receive the interventions recommended by the referring provider

DOMAIN: ADOLESCENT HEALTH
NPM 10: ADOLESCENT WELL-VISIT

ESM 10.1 Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year

Measurement Category: Category 2: Measuring quality of effort (% of reach; satisfaction)

Service Type: Middle level: enabling services

Service Recipient: Activities directed to families/children/youth

Goal: To ensure supportive programming for well adolescent visits/preventive health care.

Numerator: Number of adolescent program participants (12-21 years) who have received education on the importance of a well adolescent/preventative visit in the reporting year

Denominator: Number of adolescent program participants (12-21 years)

Significance: Adolescence is an important period of development physically, psychologically, and socially. As adolescents move from childhood to adulthood, they are responsible for their health including annual preventive well visits which help to maintain a healthy lifestyle, avoid damaging behaviors, manage chronic conditions, and prevent disease.

ESM 10.2 Percent of public middle and high schools visited to deliver pregnancy & STI prevention program

Measurement Category: Category 2: Measuring quality of effort (% of reach; satisfaction)

Service Type: Middle level: enabling services

Service Recipient: Activities related to systems-building

Goal: Increase educational awareness on sexual health (teen pregnancy and STI) to adolescents ages 12-17 years old in public schools on main islands.

Numerator: Number of public middle and high schools visited with completed delivery of pregnancy & STI prevention program

Denominator: Number of public middle and high schools.

Significance: Women who become pregnant during their teens are at increased risk for medical complications, such as premature labor, and social consequences.

DOMAIN: CHILDREN WITH SPECIAL HEALTH CARE NEEDS
NPM 12: TRANSITION

ESM 12.1 Percent of youths with Special Health Care Need (CSHCN) enrolled in the non-medical related programs to receive services.

Measurement Category: Category 2: Measuring quality of effort (% of reach; satisfaction)

Service Type: Bottom level: public health services and systems

Service Recipient: Activities directed to families/children/youth

Goal: Collaborate with inter-governmental agencies, business, and non-profits to provide CHSCHN with non-medical related services.

Numerator: Number of CSHCN youth registered for non-medical related services

Denominator: Total number of CSHCN youth in the registry

Significance: By involving business representatives on the council, it is our hope that the business community will learn more about the children and youths with special health care needs and the transition program and therefore provide them with employment opportunities.

DOMAIN: CROSS CUTTING/LIFE COURSE
NPM 13: PREVENTATIVE DENTAL VISIT

ESM 13.1 Number of children ages 1-17 years receiving preventive dental care from a dentist.

Measurement Category: Category 4: measuring quality of effect (% of "is anyone better off")

Service Type: Bottom level: public health services and systems

Service Recipient: Activities directed to families/children/youth

Goal: Increase preventive dental visits among children in elementary and high schools.

Numerator: The number of children, ages 1 through 17 who had a preventive dental visit in the past year

Denominator: The number of children ages 1-17 enrolled in elementary or high schools.

Significance: RMI MCH Program recognize the integral role of maintaining oral health across the lifespan, beginning before a child is born and continuing until the end of life. Poor oral health impacts overall health and well-being; a child's ability to learn, grow and thrive; self-esteem; employability; and overall quality of life. The "Life Course Theory" conceptual framework points to broad social, economic and environmental factors as underlying causes of inequalities in health, with oral health being no exception. The two most prevalent oral diseases, dental caries (cavities) and periodontal (gum) disease are chronic, communicable, bacterial infectious diseases that are almost entirely preventable and manageable if detected in the early stages of the disease. Dental caries is the most common, chronic disease in children, five times more common than asthma and seven times more common than hay fever. If a child develops tooth decay at an early age, they are more likely to have a lifetime of pain and suffering from poor oral health.

ESM 13.2 Percentage of elementary schools visited by dental program

Measurement Category: Category 2: Measuring quality of effort (% of reach; satisfaction)

Service Type: Middle level: enabling services

Service Recipient: Activities related to systems-building

Goal: Increase the number of schools visited to educate and provide preventive measures (varnish & sealant).

Numerator: Number of elementary and high schools visited by dental program

Denominator: Number of elementary and high schools

Significance: Oral health is a vital component of overall health. Schools support student success by providing oral health care assessment, intervention, and follow-up for all children within the school setting. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits.

Strengths and Weaknesses of the Process

Overall, the process accomplished what it was designed to do gather broad stakeholder input and to ensure that all population domains were given adequate time and attention.

The primary strength of the process was the focus on partnerships. These partnerships put Title V in a position to maximize resources. Many partnerships were in place before the Needs Assessment, with many new partnerships developing throughout, and assisted to develop effective programs and policies that address the needs of population. The process promoted a life course approach with MCH stakeholders.

The mixed methods design provided opportunities for a range of input and ensured diverse representation across the state: from parents to providers; and urban to rural areas.

The primary weakness was the need for more time. While the process began early and generated buy-in and support from partners, more opportunity to engage in discussions with key partners, including mental/behavioral health systems and schools, may have strengthened strategies related to those issues. These conversations will occur in the coming year and will assist in the revision of state objectives and strategies

Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

Summary of Needs Assessment Process

In 2020, a comprehensive review of MCH population needs, program/workforce capacity, and partnerships that are critical components of the state system to provide care to MCH populations was undertaken. The assessment data collection process helped to identify the strengths and weaknesses, and other factors affecting MCH Services in RMI. State Priority Needs, objectives, and linking of National Performance Measures and Evidence-based/Informed Strategy Measures were derived from the needs assessment stakeholder engagement addressing of the gaps and interventions.

The process involved various departments and programs within the Ministry and other partners and stakeholders including community members to identify health priority needs and at the same time assess the capacity within the State to address these needs. This is a continuous and on-going process throughout the year as the needs may change depending on the situation(s) that may arise.

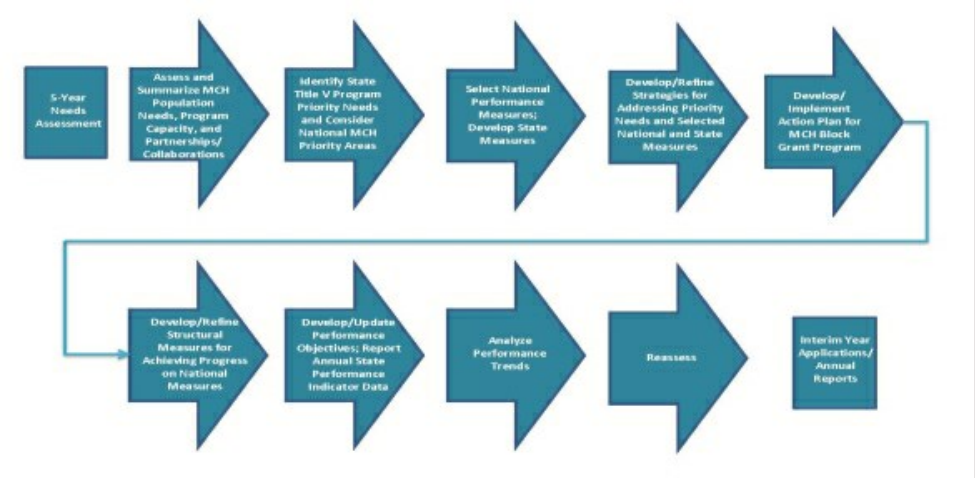
The design of the Needs Assessment, including the diversity of perspectives for input, was based on a collaborative approach that:

1. incorporated input from key stakeholders with different perspectives, not only public health professionals;
2. ensured geographical representation across the RMI; and,
3. built partnerships among stakeholders through participation in the Needs Assessment process.

Logic Model

The MCH Logic Model depicts the process used, which involves continuously analyzing performance and reassessing strategies as time progressed. This logic model served as a model for the strategic meetings as input was synthesized and defined over time and as the RMI continued to work in partnership to improve the MCH Block Grant.

Figure 5 Title V MCH Block Grant Needs Assessment Framework Logic Model



Recognizing the complexity of the Needs Assessment, RMI MCH organized a Needs Assessment team that worked with stakeholders to ensure that all domains were adequately addressed and that priorities, objectives and strategies made sense within and across population domains. The MCH 2020 Needs Assessment Coordinating team, was led by MCH Director Caroline Johnny, IT Director Edlen Anzures and Lead consultant Marshall Islands Epidemiology & Prevention Initiatives (MIEPI).

RMI's MCH 2020 was a short 1-year to the process, promoting and practicing collaboration with MCH 2020 Stakeholders and keeping the door open for public input. Key activities included:

- Host and facilitate MCH meetings
- Attend, facilitate, or present at three MCH strategic planning meetings with various stakeholders
- Conduct Focus Groups with pregnant mothers, women without children, women with children and women who gave birth in the outer islands.
- Gather input through the MCH Public Input survey.

A key difference from MCH 2015, which also engaged stakeholders and implemented solid action plans, was intentionality during MCH 2020 to build partnerships and initiate collaboration at the state and local levels including hosting stakeholder meetings with the World Bank Early Childhood Development Program and working alongside NGO partners to administer qualitative surveys.

The outcomes of this intentionality included new partnerships, cross connections between counties, and presentations that provided education about KDHE MCH services so that the state was well represented and participants were informed and valued through in-person interaction.

Table 10. RMI MCH 2020 Stakeholders

Name	Title
Caroline Johnny Jibas	RH/MCH Director
Jack Niedenthal	Secretary of HHS
Mailynn Langinlur	Deputy Secretary, PHC
Edlen J. Anzures	Health Informatics, OHPPPE
Francyne Wase-Jacklick	Deputy Secretary, OHPPPE
Dr. Ivy Clare Lapidez	OB/GYNE
Adela Nakamura	HIV/STI Program Manager
Daisy Momotaro	WUTMI Director
Lydia Tibon	KIJLE, Director
Neiar Kabua	National Comprehensive Cancer Control Program
Suzanne Phillipo	Breast and Cervical Cancer Screening Program
Dr. Dustin Bantol	Assistant Secretary, Oral Health
Herokko Lomae	Chief Nurse
Daisy Pedro	Immunization Program Manager
Ana Valotu	Ebeye-MCH Coordinator
Helen Jetnil-David	Medical Referral Director
Earlynta Chutaro	EH Director
Arata Nathan	Outer Island Director
Erma Myazoe	177 Health Administrator
Chinilla Pedro-Peter	EHDI Coordinator
Eonmita Rakinmeto	Public School System
Leilani Peren	Tobacco Coordinator/Acting NCD Director
Kathleen Candle-Jikit	Preparedness Director
Risa Bukbuk	TB Program Manager
Ken Jetton/Alex Alex	Hansen's Program
Dr. Mary Jane Gancio	Pediatrician
Norah Alex	Labor and Delivery Head Nurse
Rina Heben	Maternity Head Nurse
Joni Nashion	Clinical Chief Nurse
Frank Horiuchi	Special Education-PSS
Kainok Joseph	Youth to Youth
Rachel Bigler	ECD Health Coordinator
Molly Helkena	National Advisor, ECD
Dr. Holden-Nena	Psychiatrist
Marita Edwin	Mental Health Director
Mr. Biwij John	Faith-based
Florence Peter	CMI Nursing Program Director
Lorna Rolls/ Dr. Pulane	UNFPA
Dr. Eonyoung Ko	WHO Country Liaison Officer
Alexander Noah	Ministry of Finance, Budget Coordinator
Ilaisa Daucakacaka	Budget Performance Coordinator, MOHHS
Hermon Schmidt	Vital Statistics Director
Anne Marie Provo	Nutrition Specialist Health, Nutrition and Population Global Practice, World Bank
Nozizwe Chigonga	UNICEF

MoHHS Guiding Framework

Throughout the process, the focus was on the MoHHS' Mission Statement: " To provide high quality, effective, affordable,

and efficient health services to all people of the Marshall Islands, through a primary care program to improve the health statistics and build the capacity of each community, family and the individual to care for their own health." To the maximum extent possible, the MOH pursues these goals using the national facilities, staff and resources of the RMI.

Methods for Assessing MCH Populations

Selection factors that was included during the process:

1. Availability of resources and services within the islands
2. Challenges and success of meeting the targets
3. Strategies and activities for each state priorities
4. Mapping of information, data and sources
5. Commitment of Ministry of Health, Community, and stakeholders.

Data Sources

Both qualitative and quantitative data were implemented in the Needs Assessment process for MCH 2020. Qualitative data consisted of focus group surveys, prioritization ranking survey and stakeholder, partner, and community input and feedback at stakeholder meetings.

Quantitative indicators were compiled and presented at meetings to stakeholders and partners and much of the discussion toward determining the status of MCH and specific needs for each MCH domain came from sharing this data. Limitations were noted as data were disseminated.

Data sources included, but not limited to:

Population level
EPPSO Population Data
RMI MoHHS Annual Report 2018 (Vital Statistics)
RMI MOHHS Key Performance Indicator Dashboard, 2016-2019
MCH/RH administrative data
UNFPA reports
UNICEF ICHNS Survey 2017
Public School System Annual Report 2018

Qualitative data were used to assign meaning to the quantitative data that were reviewed. Data driven decision-making was a key factor in the Needs Assessment process and balanced the degree of data collected through meetings and surveys. This combination of proactive input provided rich and varied data.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

Status of MCH in the RMI

Projected MCH Population

Current projected population was derived from the review of RMI 2011 Census conducted by EPPSO. It is estimated that over 40% of the RMI population is under the age of 17 years.

Table 11: The Maternal and Child Health Population, 2020-2025

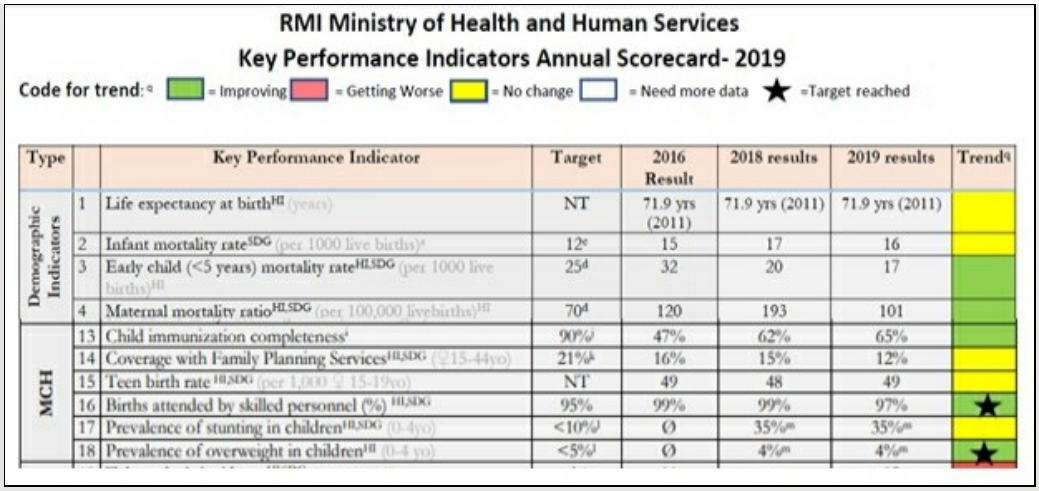
	2020	2021	2022	2023	2024	2025
Infants (<1)	1,258	1,217	1,177	1,136	1,096	1,056
Children (1-14)	20,690	20,808	20,926	21,043	21,161	21,279
Adolescent (15-17)	4,886	4,903	4,920	4,937	4,954	4,972
Women (15-44)	12,255	12,298	12,341	12,384	12,428	12,471
Population Total	54,897	55,090	55,283	55,476	55,669	55,862

Source: EPPSO RMI Projected Population, 2020-2025, RMI Household Census 2011

Demographic Indicators

A review of Key Performance Indicators Annual Scorecard from 2016 and 2019 show no change in the Infant Mortality Rate in 2019 (16) from 2016 (15). An improving trend was reported for Early child (<5 years) mortality and Maternal mortality ratio. Early child mortality rate decreased by nearly 50% (17 from 32) and below the Sustainable Development Goal (SDG) target of 25.

Figure 6. MCH Indicators, KPI Scorecard 2019



RMI Ministry of Health and Human Services

Key Performance Indicators Annual Scorecard- 2019

Code for trend: [q] = Improving = Getting Worse = No change = Need more data ★ =Target reached

Type		Key Performance Indicator	Target	2016 Result	2018 results	2019 results	Trend[q]
Demographic Indicators	1	Life expectancy at birth[HI] (years)	NT	71.9 yrs (2011)	71.9 yrs (2011)	71.9 yrs (2011)	
	2	Infant mortality rate[SDG] (per 1000 live births)[a]	12[e]	15	17	16	
	3	Early child (<5 years) mortality rate[HI,SDG] (per 1000 live births)[HI]	25[d]	32	20	17	
	4	Maternal mortality ratio[HI,SDG] (per 100,000 livebirths)[HI]	70[d]	120	193	101	
MCH	13	Child immunization completeness[i]	90%[j]	47%	62%	65%	
	14	Coverage with Family Planning Services[HI,SDG] (♀15-44yo)	21%[k]	16%	15%	12%	
	15	Teen birth rate [HI,SDG] (per 1,000 ♀ 15-19yo)	NT	49	48	49	
	16	Births attended by skilled personnel (%) [HI,SDG]	95%	99%	99%	97%	★
	17	Prevalence of stunting in children[HI,SDG] (0-4yo)	<10%[j]	Ø	35%[m]	35%[m]	
	18	Prevalence of overweight in children[HI] (0-4 yo)	<5%[j]	Ø	4%[m]	4%[m]	★

Source: Key Performance Indicators Annual Scorecard 2019, RMI MoHHS

Prenatal Visits

It is not uncommon for women in the RMI to visit the hospital for their first Prenatal visit late in their 2nd or 3rd trimester. The Reproductive Health clinics observe that over 20% of mothers visit the hospital for their first prenatal booking in the 3rd trimester, with some coming into the hospital just in time for delivery.

Table 12. First prenatal visit by trimester, for women (≥20 years) and teens (≤19 years), 2010-2019, RMI

YEAR	FIRST PRENATAL VISIT				FIRST TEEN PRENATAL VISIT			
	1st Trimester	2nd Trimester	3rd Trimester	Total	1st Trimester	2nd Trimester	3rd Trimester	Total
2019	261	396	194	851	33	85	20	138
2018	283	382	189	854	42	79	25	146
2017	215	382	199	796	39	74	29	142
2016	318	421	198	937	51	85	29	165
2015	261	405	183	849	42	66	26	134
2014	218	330	164	712	39	35	20	94
2013	287	410	207	904	53	65	16	134
2012	201	350	135	686	28	44	9	81
2011	66	135	67	268	7	10	4	21
2010	125	286	134	545	17	64	16	97

Source: Administrative log books, Reproductive Health Clinic, MoHHS, 2019

Family Planning Users

In the RMI, the large majority of family planning users recorded at the Reproductive Health Clinics are females.

Table 13.Unduplicated Family Planning users, 2010-2019, RMI

YEAR	UNDUPLICATED FP USERS		
	Female	Male	Total
2019	1909	20	1,929
2018	1932	9	1,941
2017	1967	7	1,974
2016	2200	15	2,215
2015	1153	23	1,176
2014	1970	51	2,201
2013	2520	39	2,559
2012	2562	43	2,605
2011	1582	59	1,641
2010	1708	118	1,826

Source: Administrative log books, Reproductive Health Clinic, MoHHS, 2019

In 2017, only 16% of women 15-44 years who used any form of contraception. The most common form of Family planning method was female sterilization, followed by 3-month hormonal implant. Less than 13% of women 15-44 used oral contraceptives.

Table 14: Contraceptive Rate 2011-2017 and Unduplicated users by preferred Family planning method 2017, RMI

: Contraceptive Prevalence Rate, RMI, FY2011-FY2017							
Description	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
No. of Women 15-44 yrs old that used at least one method of contraception	1,234	1,373	1,721	1,917	1,836	1,826	1,825
No. of 15-44 yrs old women	11,867	11,799	11,757	11,746	11,751	11,761	11,773
Contraceptive Rate	10%	12%	15%	16%	16%	16%	16%
Source: Family Planning Program							

RMI Unduplicated Female Users Family Planning Services, 2017										
	<15	15-17	18-19	20-24	25-29	30-34	35-39	40-44	>44	Total
Primary Method										
Female Sterilization	0	0	0	18	190	200	145	50	41	644
Hormonal Implant	4	17	42	88	91	90	51	12	7	402
3-Month hormonal injection	8	25	50	149	112	112	72	61	14	603
Oral Contraceptive	1	15	21	46	46	49	36	16	12	242
Female Condom	0	0	1	0	0	3	0	1	0	5
Fertility Awareness Method (FAM)	0	0	0	0	0	0	0	0	0	0
Intrauterine Device (IUD)	0	0	0	1	0	0	0	0	0	1
Abstinence	0	0	0	0	1	0	0	0	0	1
Unknown Method	0	0	3	5	4	5	3	0	2	22
Total	13	57	117	307	444	459	307	140	76	1,920
No Method										
Pregnancy or Seeking Pregnancy	7	45	111	282	246	210	116	26	8	1,051
Other Reason	0	2	17	35	56	49	31	21	21	232
Total	7	47	128	317	302	259	147	47	29	1,283

Source: RMI Ministry of Health and Human Services Annual Report FY17

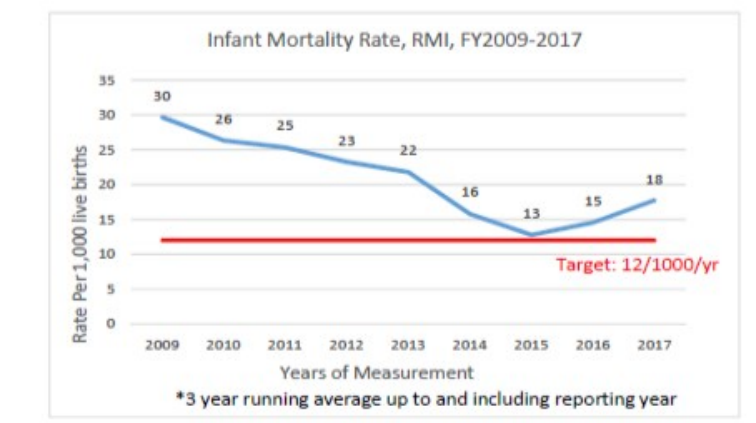
Infant birth weight

Description	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Registered Birth	1,396	1,487	1,316	1,308	1,199	1,116	1,089	1,024
Crude Birth Rate Per 1,000 Live births	26	28	24	24	22	20	20	18
Total Fertility Rate	3.18	3.38	3.05	3.03	2.71	2.74	2.69	2.59
Rate of Natural Increase	2.04%	2.12%	2.12%	1.83%	1.72%	1.34%	1.33%	1.26%
LBW	186	181	167	180	156	196	120	130
VLBW	26	10	17	9	6	14	6	14
Premature	74	90	50	36	78	66	91	104

Table 15. Summary of Birth Information, RMI 2010-2017
Source: RMI Ministry of Health and Human Services Annual Report FY17

Infant Mortality Rate

Figure 7. Infant Mortality Rate, RMI 2009-2017



Source: RMI Ministry of Health and Human Services Annual Report FY17

Table 16. Infant Causes of Death, RMI 2017

Underlying Cause of Death	*Count*
Premature	5
Pneumonia	4
Sepsis	2
Asphyxia	2
Asthma	1
Congenital Heart Disease	1
Malnutrition	1
Meconium Aspiration	1
Meningitis	1
Prolonged Labor	1
Septicemia	1

Source: RMI Ministry of Health and Human Services Annual Report FY17

Dental Services

In 2020, the Dental Clinics saw over 7,042 patients, with nearly half of these were extraction cases.

Table 17. Patients seen at Dental Clinics by Dental Service received, RMI 2020

Total Patients	7,042
Prenatal	420
Diabetic/NCD	571
School Students Examine/Treated	3,433
Extractions	5,262

In 2020, the Dental Clinics observe on average 200-300 patients in the RMI were elementary age children (1-14 years). With over 80% of these cases were children seen are due to pain, often resulting in tooth extractions.

Dengue Outbreak in RMI June 2019 – September 6, 2020

	Ebeye	Majuro	Utrik	Aur	Maloelap	Mili	Ailinglaplap	Wotje	Arno	Namu	Ene-wetak	Jaluit
# Dengue Like Illness cases	276	3147	42	34	2	6	1	1	58	3	12	9
# New in Past 7 Days	0	18	0	0	0	0	0	0	0	0	0	0
# Hospitalized	142	923	9	3	0	0	0	0	0	0	0	7
# in Hosp Now	0	7	0	0	0	0	0	0	0	0	0	0
# Died	0	1	0	0	0	0	0	0	1	0	0	0
# NS1 or IgM+ (# Tested)	130 (180)	1,479 (3146)	9 (13)	29 (32)	2 (2)	6 (6)	1 (1)	1 (1)	50 (54)	1 (3)	4 (12)	7 (9)
# PCR+ (# Tested)	15 (17)	13 (23)	3 (3)	0 (2)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)

Cases: After the initial cases in Ebeye in May 2019 transmission soon occurred to Majuro. A travel ban to the Outer Islands kept them without cases until it was lifted in November 2019. Atolls affected include Utrik, Aur, Maloelap, Mili, Ailinglaplap, Wotje, Arno, Namu, Enewetak and Jaluit**. Currently only Majuro has new cases, continuing the lower-level transmission**. To date there have been **3,591 dengue like illness of which 1,719 have been lab confirmed. Two deaths (Majuro and Arno) and one severe dengue patient evacuated out-of-country to date.**

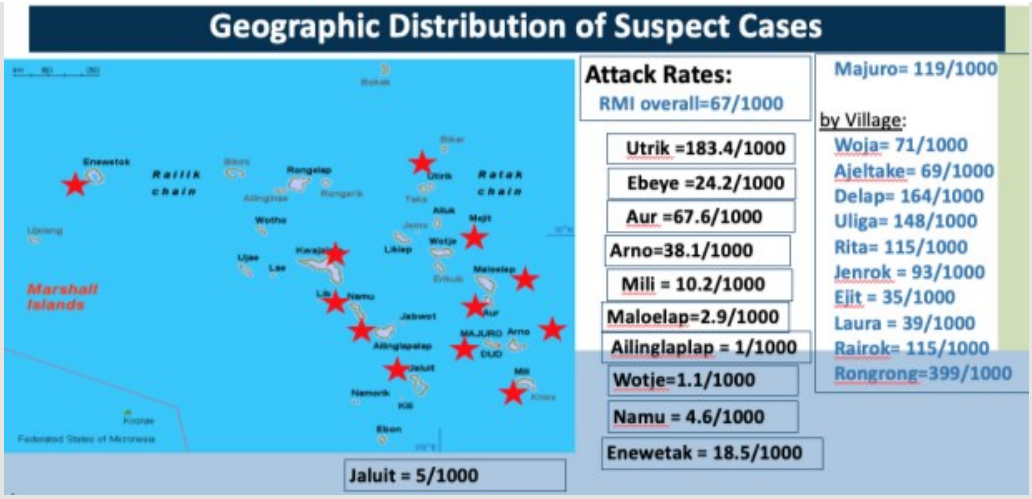
Organization of Response:

- **EpiNet teams activated on July 16, 2019 and now with declining cases meet 1x/week**.
- Presidential Declaration of Health Emergency and activation of multi-ministry and NGO National Emergency Operations Center on August 6, 2019 and RMI Dengue Response Plan finalized
- Conference calls with technical assistance partners held as needed.

Case Definitions (based on PPHSN):

Probable case: Acute fever > 2 days with **two or more** of the following: anorexia and nausea; aches and pains; rash; low white blood cell count; tourniquet test positive; warning signs *(abdominal pain or tenderness; persistent vomiting; mucosal bleeding; liver enlargement; lethargy, restlessness; increase in hematocrit with decrease in platelets)*.

Confirmed case: Suspected case with lab confirmation (+Rapid test (for NS1 or IgM) or +PCR test)



Current Response Goals:
1) Slow spread in affected atolls; prevent spread to other outer atolls, 2) Assure excellent clinical care to minimize deaths, 3) Stop transmission entirely

Surveillance: **Daily Active surveillance continues Majuro, Ebeye, and Outer islands with some communication challenges.**

Vector Surveillance and Control: 1) fumigation of houses of new cases in Majuro continues, 2) Ongoing Fumigation on vessels. **Mosquito trapping is continuing and specimens will be sent to CDC for identification and virus testing.**

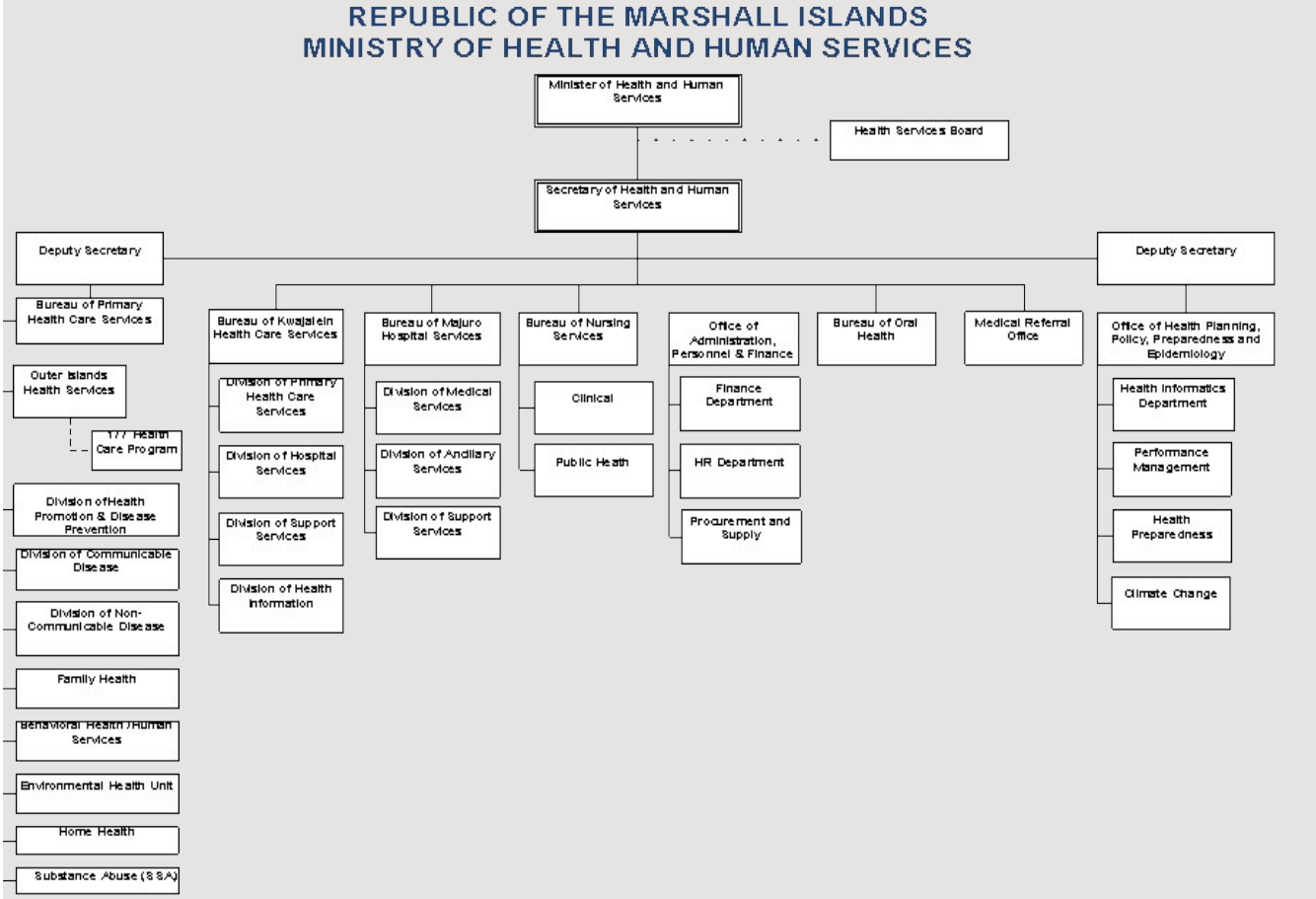
Outer Islands: An Outer Islands Protocol was implemented to include training of OI Health Assistants to perform Dengue Rapid Test; Patient Care Management; **One new case identified in Mili Atoll signifying reintroduction to that Atoll. Public Health & Environmental team is going for investigation and mosquito eradication.**

Majuro: **Cases continue to be in double digits (18) in the last week; the high-density villages of Rita (3) and Delap (5) and Woja (3) are the hotspots at this time. Of the 18 new cases, 8 (44%) were hospitalized; 1 discharged with the average length of stay at 5 days; 7 remain hospitalized (2 pediatric, 5 adults)**

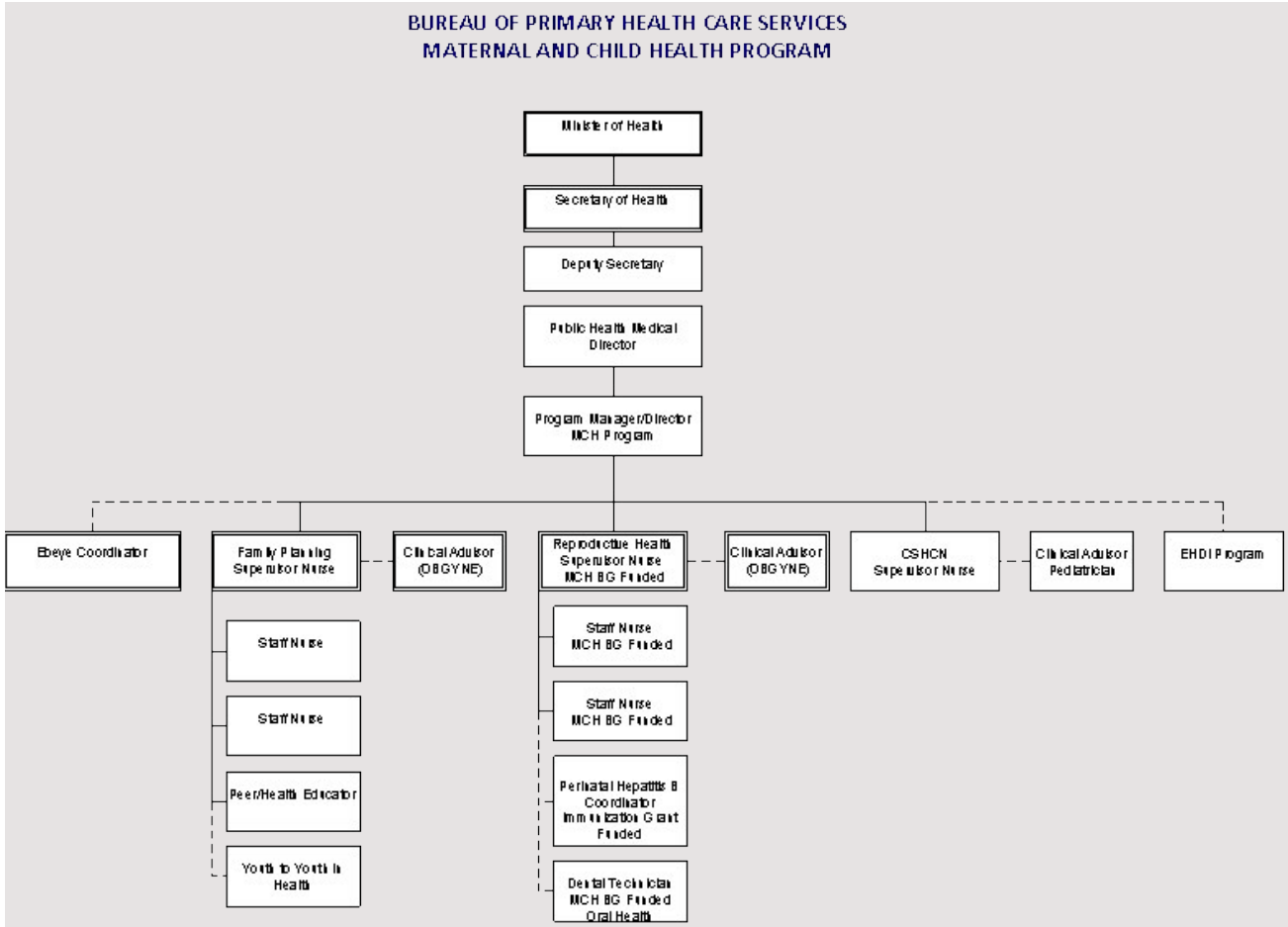
Travel Advisory: There is no current travel restriction from outer atolls/islands to/from Majuro and or Ebeye by sea and/or air

Health Education: Ongoing radio awareness in V7AB, 103.5 and new radio station 90.7 discuss the ongoing dengue activities and data; Dengue Fever SitRep in MIJ Newspaper updated weekly; MOHHS Facebook posting of updated situation reports, health alerts and other related activities. **More Community Participation is being encouraged to stop the outbreak. WASH cluster is resuming meetings to work with MalGov and MAWC for community cleanup.**

III.C.2.b.ii. Title V Program Capacity
III.C.2.b.ii.a. Organizational Structure



Republic of the Marshall Islands, Ministry of Health and Human Services, Organization Chart 2020



III.C.2.b.ii.b. Agency Capacity

Agency Capacity

The MCH/CSHCN Program coordinator is a member of the Ministry of Health and Human Services Core Committee which coordinates all community awareness activities. The MCH program is also a member of the RMI Interagency Council under a Memorandum of Understanding as well as parent representatives. The Interagency Council meets regularly to ensure continuous services are provided to all CSHCN, both in school and those who are not.

The program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information system) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and aerial resources necessary to meet public health obligation. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcomes, and risk factors.

The State Program Collaborate with other States Agencies and Private Organization. State establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

The State support for communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improvement and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standard/guidelines, training, data and planning systems. Examples include needs assessment, monitoring, training, applied research, information systems and systems of care. In the development of system of care it should be assured that the systems are centered, community based and culturally competent.

III.C.2.b.ii.c. MCH Workforce Capacity

Workforce development/Capacity building

Health Organization: National MCH/RH Program is under the Bureau of Primary Health Care Services. As the national program, MCH Director work closely with Majuro, Ebeye, Outer Islands and 177 Health Care Program on MCH program and activities.

Secretary of Health and Human Services - Mr. Jack Niedenthal. Secretary Niedenthal advocates the work plan and activities of the MCH Block Grant.

Deputy Secretary of Health and Human Services: Mailynn Konelios-Langinlur. She provides advice and support to the program alongside with Public Health Medical Director. MCH Director reports directly to the Deputy on administrative functions of the program.

Public Medical Director: Acting / Dr. Frank Underwood. Dr. Underwood provides over all clinical advise to the MCH Program alongside the OBGYNs and Pediatricians.

Staff funded under MCH Block Grant

MCH Director: Caroline Johnny-Jibas. Caroline graduated from the College of the Marshall Islands in 1995 with an AS Degree. She started working in 1996 as a Public Health Zone Nurse before she was promoted to be the Hansen's disease program coordinator in 2011. She was transferred to MCH program as the director in April of 2016. She manages and coordinates all the activities between all clinics, health centers and stakeholders. Funded under the Compact funds.

CSHCN Coordinator: Caroline Johnny-Jibas. Currently, Caroline is the coordinator until a new one is hired. Position will be open in the next budget period. As the CSHCN Coordinator, she works closely with Pediatricians, Pediatric Ward Head Nurse, MCH nurses, EHDI (Early Hearing Detection Initiative) Program, Medical Referral Services, Public School systems and Shriner's Hospital. She is also member of the committee leading the World Bank Project: RMI Early Childhood Development Program.

Staff Nurse: Maypol Briand, Carlwin Aisea, Eomra Lokejak and Johanna Rilang. The three staff nurses graduated with AS Nurse degree in College of the Marshall Islands. They are responsible for Women's Health Clinic, Prenatal and Post-Natal Clinic, Youth to Youth Clinic and leads MCH related outreach mobile visits. Funded under MCH Block Grant.

Dental Assistant: Kim Laidren. She overlooks pregnant women referred to the dental clinic and refer patients when further evaluation and treatment is needed. Funded under MCH Block Grant.

Staff working with MCH Program funded under different grants

Family Planning Services Staff: Tauki Korean, Jacqueline Mojilong, **Whynonna Wonne** and **Komi Mea**. These staff are paid under Title X – Family Planning Grant. Aside from their family planning activities, they are also working with the Women's Health, Prenatal and Post-Natal clinics, Youth to Youth in Health Clinic and outreach activities

Ebeye MCH Coordinator: Ana Valotu. She handles Women's Health, Prenatal and Post-Natal Clinic, and Family Planning Services in Ebeye Hospital along with 1 nurse.

OBGYNE: Dr. Meeankshi Prathak, Dr. Ivy Claire Lapidez, Dr. Corazon Rivera, Dr. Andrea Abello. There are 3 OBGYNs on Majuro and 2 on Ebeye.

Pediatrician: Dr. Mary Jane Gancio, Dr. Menasa Baleinamau, Dr. Venus Jopia, Dr. Paz Estoesta. There are 3 Pediatricians in Majuro and 1 in Ebeye

SSDI Coordinator: Edlen J. Anzures. She graduated from Adamson University with a degree of B.S. Computer

Engineering and recently finished DDM (Data for Decision Making) course under Fiji School of Medicine. She works closely with MCH Director on the activities supported by SSDI. She is also the Health Informatics Director of the Ministry of Health and Human Services.
SSDI Data Encoder/Administrative Staff: She is funded under SSDI grant. She works closely with MCH Director, assist in the administrative needs of the program and enters encounter forms for MCH/RH program.
Deputy Secretary of Health and Human Services: Francyne Wase-Jacklick. She graduated in Hawaii Pacific University with a degree of B.S. Biology and A.S. Biology in Mt. St. Mary College. She provides support in the monitoring and evaluation of the work plan of the MCH Program. Mrs. Wase-Jacklick was recently promoted to Deputy Secretary.
Nurse Practitioners: There are 10 Nurse Practitioners that rotate duty in the MCH, RH, Immunization and other Public Health programs. They were trained to handle prenatal, family planning, cancer screening, ncd screening and management, immunization services and other PH activities.
Medical Interns: There are 6 medical interns that are rotating in MCH clinics and activities as part of their training.

National MCH Program under the Bureau of Primary Health Care Services aims to keep the goal of the bureau: Preventative and public health services will be efficiently maximized through a healthy islands lifestyle concept and with essential medical and administrative functions to ensure that the health and life span of various individuals, families and communities are enhanced.

The Bureau of Preventative and Public Health includes the following departments:

Outer Island Health Services
Communicable Diseases
- *STD/HIV*
- *Leprosy*
- *Tuberculosis*

Non-Communicable Diseases
- *Diabetes*
- *Hypertension*
- *Cancer Control Program*

Maternal and Child Health
Immunization
Behavioral Health
Health Promotions
Zone Health/Community Outreach
Administration

There is streamlining of program activities and coordination and reduction of silos to avoid duplication of efforts and over-all improvement of services for MCH population.
Improvement Plan on Workforce and Capacity Building
1. Create and implement a MCH 101 training module for new and old employees.
2. Monthly meetings on quality improvement of MCH State Action Plan
3. Continue the MCH Workshop

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Partnerships and collaborations

The MCH program collaborates with all the programs in Public Health and other partners, local and international in providing quality and essential services to the target population on Majuro, Ebeye and the outer islands. Such services include oral health hygiene, STI/HIV services, Non communicable diseases, non-communicable diseases, mental health and human services, Cancer Program, TB and Leprosy program, EHDI, Outer Islands Health Centers, wellness and 177 Health Care program.

The MCH program also partners and collaborates with international programs such as UNICEF, UNFPA and WHO. UNICEF, in collaboration with MCH, MOHHS conducted the Nutritional Survey in 2017 and other activities for the immunization program. UNFPA, in collaboration with MCH, MOHHS in 2018 conducted the Health Facility Readiness Service Availability (HFRSA), with the results and findings releasing October 2020 and other activities targeting women's health and reproductive health. A workplan for RMI has been created to with activities to implement. UNFPA also provided capacity building to the staff to improve counselling services and Gender Based Violence. The program also collaborates with World Bank on the activities for the Early childhood program for the MOHHS component. Workplan has been created with activities to implement. WHO provides assistance in training of midwives and other fields related to MCH.

MCH partners and collaborates with local NGOs like WUTMI, YTYIH, MIEPI and government agencies like Ministry of Culture and Internal Affairs and Public-School System for MCH activities.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Identifying Priority Needs and Linking to Performance Measures

MCH Domain	NPM #	State Priority	Evidence Based/Informed Strategy Measures	State Performance Measures
Women/ Maternal Health	NPM 1	Access to coordinated, comprehensive care and services for Women before, during and after pregnancy. Cancer screening and services for Women's Health	1.1 Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year. 1.2 Number of community health centers that provide cancer screening/referrals for women 1.3 Percent of women booked for prenatal visit in first trimester. 1.4 Percent of women receiving postpartum follow-up health care services within the first four to six weeks after delivery.	SPM 1: Percent of Women ages 25-49 years old screened for cervical cancer. SPM 2: Percent of women ages 15-44 years old that use family planning services SPM 3: Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy
Perinatal/ Infant Health	NPM 3	Reduce Infant Mortality Rate	1.1 Number of birthing hospitals re-designated with updated standard operating procedures (SOP). 1.2 Percent of birthing hospitals who complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually 1.3 Percent of newborn babies issued newborn baby passports	SPM 1: Training on the updated clinical guidelines and protocols for Obstetrics and Gynecological conditions
Perinatal/ Infant Health	NPM 4	Infants breastfed exclusively through six months	4.1 Percent of women provided with in-person or telephonic breastfeeding consults/support services 4.2 Number of MCH staff and community health workers attended the Certified Lactation Counselor training.	
Child Health	NPM 6	Parent-completed developmental screening tools	6.1 The number of potential high risk screens referred to early intervention.	SPM 3: Increase percentage of fully immunized children ages 19 to 35 months
Adolescent	NPM 10	Child Oral Health	10.1 Percent of adolescent program	SPM 5: Increase use of

Health		Program partnership with schools Teen reproductive health and pregnancy prevention	participants (12-21 years) that received education on the importance of a well-visit in the past year 10.2 Percent of public middle and high schools visited to deliver pregnancy & STI prevention program	Family planning services to teenagers ages 13 to 17 years old.
Children with Special Health Care Needs	NPM 12	Develop and implement clinical management, guidelines and registry for Children with Special Health Care Needs.	12.1 Percent of youths with Special Health Care Need (CSHCN) enrolled in the non-medical related programs to receive services.	SPM 2: Final and endorsed readiness assessment of RMI MOHHS to handle Autism Spectrum Disorder, Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder Program.
Cross-Cutting/ Life Course	NPM 13	Child Oral Health Program partnership with schools	13.1 Number of children ages 1-17 years receiving preventive dental care from a dentist. 13.2 Percentage of elementary schools visited by dental program	

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$226,608	$204,914	$226,276	$199,753
State Funds	$200,000	$200,000	$200,000	$200,000
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$426,608	$404,914	$426,276	$399,753
Other Federal Funds	$224,374	$212,229	$134,000	$134,000
Total	$650,982	$617,143	$560,276	$533,753

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$226,000	$223,723	$228,778	
State Funds	$200,000	$2,646,295	$200,000	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$426,000	$2,870,018	$428,778	
Other Federal Funds	$150,000	$184,125	$150,000	
Total	$576,000	$3,054,143	$578,778	

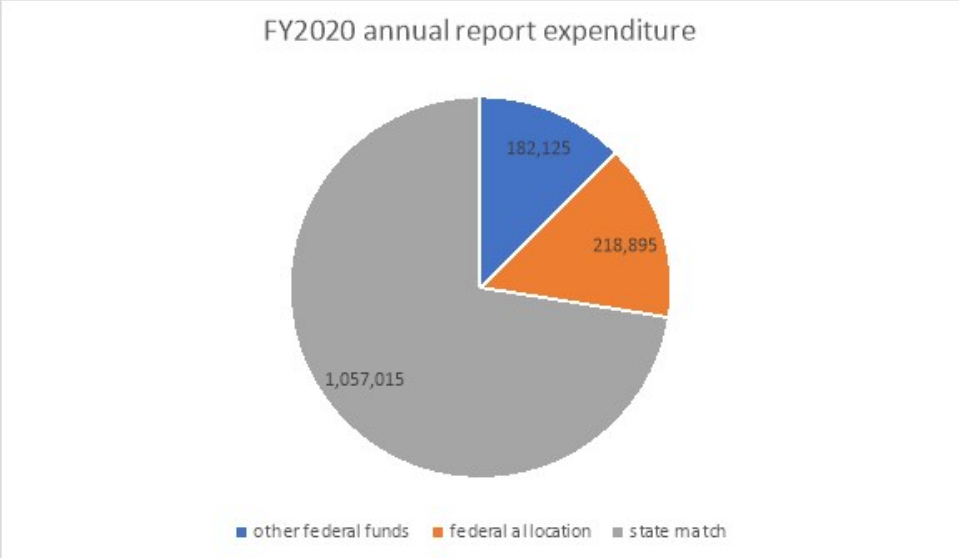
	2022	
	Budgeted	Expended
Federal Allocation	$229,808	
State Funds	$2,646,295	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$2,876,103	
Other Federal Funds	$200,000	
Total	$3,076,103	

III.D.1. Expenditures

III.D.1.

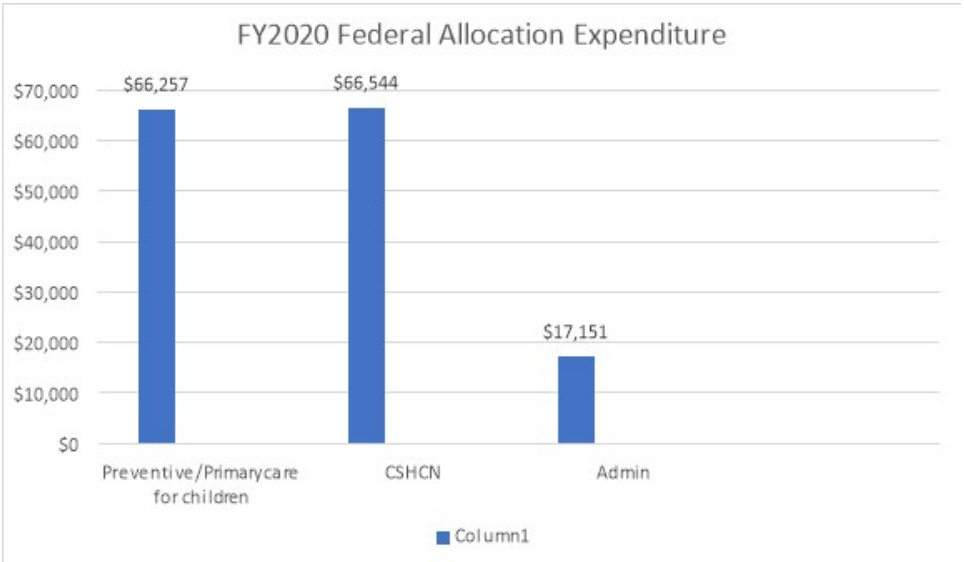
Overview of Expenditures:

The mission of the RMI Maternal and Child Health Program is to promote and improve the health and wellness of women, infants, children, including children with special health care needs, adolescents, and their families through the delivery of quality prevention programs and effective partnerships. The program works towards achieving these comprehensive services through the Bureau of Primary Health Care along with its internal and external partnerships. During the Fiscal Year 2020, from 10/01/2019 through 09/20/2020, the RMI Maternal and Child Health Program expended total funds of $218,895.00. As of 9/30/2020 the total unobligated amount is $8,248.00. Of the total unobligated amount of $8,248.00, $5449.00 is allocated for travel and $3,899.00 for supplies for the program



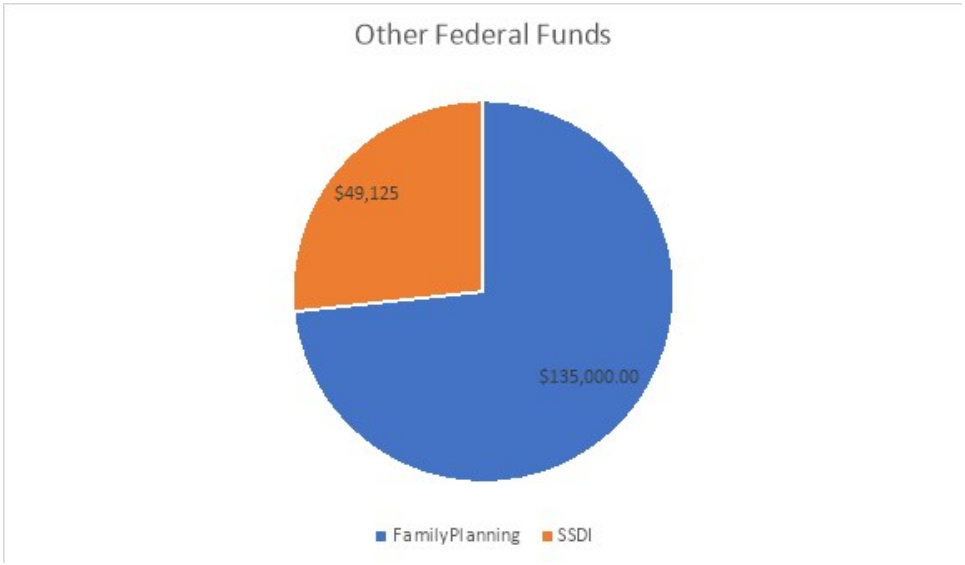
Legislative Requirements Met:

The RMI MCH Program is continuously striving to ensure that the program is complying with the legislative financial requirements for the Title V Block Grant. The MOF Federal Grant Coordinator officer/ Ministry of Finance provides the program a monthly fund status report that consist of current funds available, funds encumbered, funds expended, and the legislative required 30-30-10 percentage status report. The Ministry of Health and Human services Performance Based Budget Coordinator and fiscal officers do monthly budget reconciliation with program to monitor and track expenditures to ensure compliance with the legislative financial requirements. Expenses are monitored and tracked through a database at the Ministry of Finance. The Title V legislation requires a minimum of 30% of the block grant funds to be utilized for preventive and primary care for children and a minimum of 30% of the block grant funds for services for CSHCN. In addition, no more than 10% of the grant may be used for administration costs. The CNMI MCH Program has met the required legislative percentages for FY 20. The chart below provides an overview of the required federal allocation for the FY 20 expenditures.



Other Federal Funds:

The chart below provides an overview of the Other Federal Funds expended that were under the direct authority of the MCH program manager which are also listed in Form 2 (Family Planning and SSDI) The amount expended in FY 2020 is $182,125.00



Total State Match:

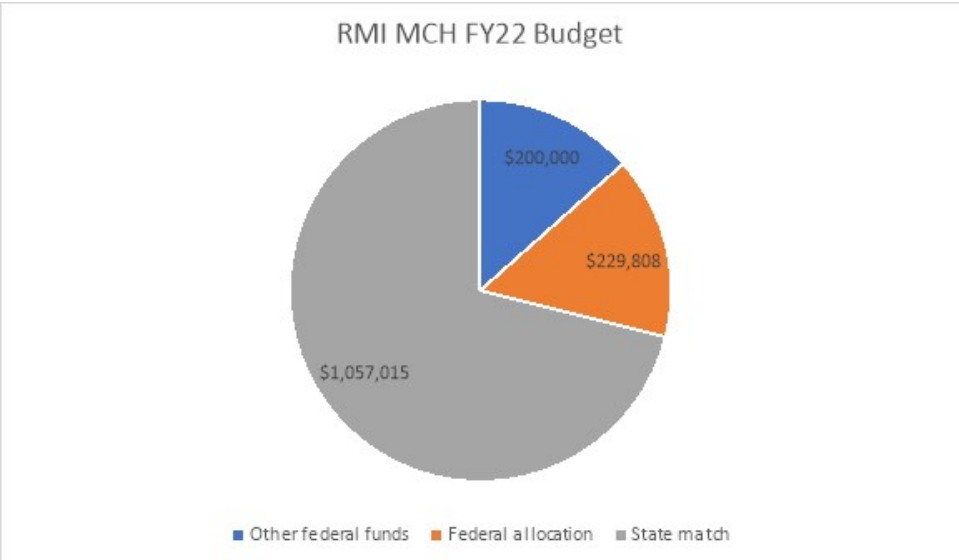
The Total State Matching funds in the amount of $1057,015.00 was expended for FY 2020. Most of the total Other Funds were expended towards personnel salaries at the Majuro Hospital and Ebeye Hospital that provide direct services to the MCH population. Since the Other Funds contribute to direct services, majority of the Title V funds contribute to enabling services and public health services and systems.

III.D.2

Budget

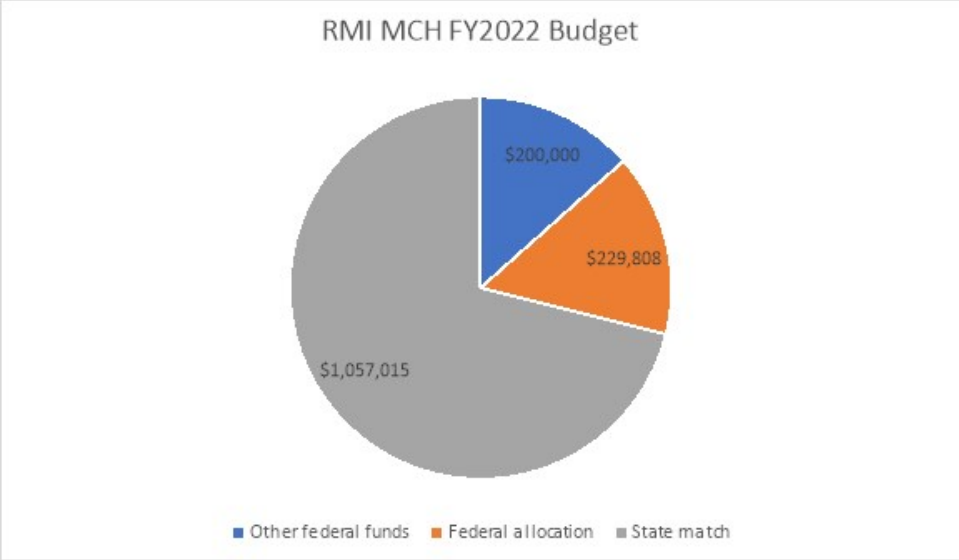
Budget Overview

The mission of the RMI Maternal and Child Health program is to promote and improve the health and wellness of women, infants, children, including children with special health care needs, adolescents, and their families through the delivery of quality prevention programs and effective partnerships. The program works towards achieving these comprehensive services through the Bureau of Primary Health Care along with its internal and external partnerships. The FY 2022 estimating a total state MCH program budget of $1,486,823M. The MCH Program's State Action Work Plan has been developed based on the Needs Assessment and current emerging issues. Therefore, the MCH Program's State Action Work Plan determines where the MCH federal grant dollars are budgeted. The MCH grant, all Other Federal Funds and the Total State Match continues to align its comprehensive goals and objectives to effectively serve the MCH population. The Title V funds consist of personnel salaries and fringe benefits and insurance that support the following staffing:1 Midwife, 2 program nurse, 1 CSHCN program staff, 1 dental assistant who works closely with pregnant mothers. These personnel work not only for the MCH Program but contribute to activities that support the MCH activities. The MCH program manager is funded 100% under the Compact funds. In addition to personnel salaries and fringe benefits, the Title V funds are budgeted towards Professional Services such as contractual and other costs to support the MCH Programs activities and initiatives stated on the State Action Work Plan. Funds also support MCH TA trainings and other trainings for staff that provide essential services to the MCH population. Public education and awareness costs include print, radio, local newspapers, television and social media posts on the importance of preventive screenings, annual preventive visits and prenatal care. Community awareness includes publicizing available services and programs, oral health care, breast feeding, and women's health services. Title V funds will be utilized to support the costs of pap kits, pregnancy test kits, STI reagents and other needed medical supplies. Funds are also utilized towards other costs such as travel, communication. The chart below provides an overview of the RMI MCH Program 2022 Budget as reported on Form 2.



III.D.2. Budget

The mission of the RMI Maternal and Child Health (MCH) Program is to promote and improve the health and wellness of women, infants, children, including children with special health care needs, adolescents, and their families through the delivery of quality prevention programs and effective partnerships. The program works towards achieving these comprehensive services through the Bureau of Primary Health Care Services along with its internal and external partnerships. The FY2022 estimating a total state MCH program budget of $1,486,823. The MCH Program's State Action Work Plan has been developed based on the Needs Assessment and current emerging issues. Therefore, the MCH Program's State Action Work Plan determines where the MCH federal grant dollars are budgeted. The MCH grant, all Other Federal Funds and the Total State Match continues to align its comprehensive goals and objectives to effectively serve the MCH population. The Title V funds consist of personnel salaries and fringe benefits and insurance that support the following staffing:1 Midwife, 2 program nurses, 1 CSHCN program staff, 1 dental assistant who works closely with pregnant mothers. These personnel work not only for the MCH Program but contribute to activities that support the MCH activities. The MCH program manager is funded 100% under the Compact funds. In addition to personnel salaries and fringe benefits, the Title V funds are budgeted towards Professional Services such as contractual and other costs to support the MCH Programs activities and initiatives stated on the State Action Work Plan. Funds also support MCH TA trainings and other trainings for staff that provide essential services to the MCH population. Public education and awareness costs include print, radio, local newspapers, television and social media posts on the importance of preventive screenings, annual preventive visits and prenatal care. Community awareness includes publicizing available services and programs, oral health care, breast feeding, and women's health services. Title V funds will be utilized to support the costs of pap kits, pregnancy test kits, STI reagents and other needed medical supplies. Funds are also utilized towards other costs such as overtime, domestic travels, communication, and support for medical referral of CSHCNs. The chart below provides an overview of the RMI MCH Program 2022 Budget as reported on Form 2.



III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Marshall Islands

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

Title V Background

Specified in the Title V legislation [Section 501(a)(1) of Title V of the Social Security Act], clearly articulated Vision and Mission statements serve a useful role in helping to guide priority setting within the federal and state MCH programs. The following Vision/Mission statements were developed as part of the MCH Block Grant transformation process.

Vision: Title V envisions a nation where all mothers, children and youth, including CSHCN, and their families are healthy and thriving.

Mission: The mission of Title V is to improve the health and well-being of the nation's mothers, infants, children and youth, including children and youth with special health care needs, and their families.

P**urpose:** As defined in section 501(a)(1) of the Title V legislation, the purpose of the MCH Services Block Grant Program is to enable each state:

1. To provide and to assure mothers and children (in particular those with low income or with limited availability of health services) access to quality MCH services;

2. To reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women, and to promote the health of children by providing preventive and primary care services for low income children;

3. To provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI, to the extent medical assistance for such services is not provided under title XIX; and

4. To provide and to promote family-centered, community-based, coordinated care (including care coordination services, as defined in subsection (b)(3)) for children with special health care needs (CSHCN) and to facilitate the development of community-based systems of services for such children and their families.

Domains: States report financial, programmatic, and performance measure data annually in six domains. Five of the six domains are broken down by MCH population group, which includes Women/Maternal Health, Perinatal/Infant Health, Child Health, Children with Special Health Care Needs (CSHCN), and Adolescent Health. The sixth domain, Cross-cutting/Systems Building, addresses program capacity and/or the systems-building needs of a State.

State title v purpose and design:

The state title v purpose is to support services to improve health and well-being of the nation’s mothers, infants, children and youth with special health care needs and their families.

State title v supports:

- State Title V supports travel of staff to outer islands and in communities of Majuro, Ebeye and Outer Islands to provide health education and preventive screening activities.
- Provide transportation for clients to come to Majuro for follow up with OBGYNE on abnormal pap smear and via results.
- Provide funds for off island referrals for the target population to seek medical treatment. Support weekly stipends for both client and escort.
- Establish committees under the ministry to investigate outbreaks and health problems. Provide data trends and public education on health issues
- Support salary for other staff in the ministry to implement program services on Majuro, Ebeye and outer islands.
- All medical equipment used to serve the target population in the preventive and curative side.
- Collaboration with NGOs to assist in the implementation of activities under the program.
- Development of policies, for example the school immunization law and nutrition policy at schools where no vendor is allowed to sell sweet treats to students.
- Public health laws where all food handlers should go thru the medical examination in order to cook and serve a public food, school entry medical examination, taxi drivers' medical examination on tuberculosis.
- Support related programs with clinical and office supplies.
- Support Dental program’s clinic and outreach mobile visits
- Support the CSHCN interisland and off island referral

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

III.E.2.b Supportive Administrative Systems and Processes
III.E.2.b.i MCH Workforce Development

Staffing Structure

The RMI MCH workforce is primarily housed within MCH program under the Bureau of Primary Health Care. The MCH Program addresses the needs of the RMI MCH population, comply with the varying program requirements of the MCH Title V Block Grant, and link all Services with other programs under the Bureau of Primary Health Care. While most of the staff is funded by sources other than Title V, all contribute to the Title V mission and MCH priorities. For example, MCH staff also work within the Title X Family Planning Program, carrying out the implementation of RMI adolescent Domain.

While the MCH Program is working closely with the Ministry's Human Resources and Public Service Commission to improve current workforce capacity, the capacity to effectively meet the varying needs of the maternal and child population in the RMI faces challenges due to limited specialists. The MCH program was established to align priorities for all programs that serve the maternal and child populations. Each program under the Bureau of primary Health Care is responsible for administering a separate federal grant that includes individual program reporting requirements and project objectives.

Recruitment & Retention

Recruitment of all MCH program staff is handled through the Ministry's Human Resources Office and Public Service Commision policies and procedures. Staffing for the Public Health programs, including the Title V MCH Program, is largely made up of a local workforce, except for the Secretary, the MCH program manager and the SSDI who are expats. Many people move to US to complete post graduate studies. Majority stay back in US for better paying jobs.

There is a challenge in workforce recruitment due to the long process imposed by Public Service commission. Every 2 years, more than 10 local nurses graduate from the nursing school at the College of the Marshall Islands. Currently, there's been a challenge with funding to hire new graduate nurses causing some nurses to apply for other fields, like banks and other offices. Aside from the nurses who graduate from the Nursing School, RMI like other jurisdictions and territories, recruits a large majority of its nursing workforce from the Philippines and Fiji for specialties in midwifery, ER and ICU. RMI in collaboration with Taiwan established a medical program in 2016 where RMI students attend Medical school. AS of 2021, RMI has 12 new Doctors who graduated from Taiwan, 7 had passed the Internship program, 1 went off for specialty in surgery and 3 will undergo internship beginning Sept 2021. There are 2 more students going to Taiwan on Scholarship for the field of Cytology and master's in nursing. There was a raise in salary for newly graduate nurses in 2018 to $13,045.00 per annum , compared to previous years, this was done to attract people to go into nursing.

Training

The RMI MCH program in collaboration with other public health programs is to provide comprehensive and holistic community health services, including medical, dental, mental health and substance abuse screening, perinatal,

nutrition, and family planning, all supplemented by enabling services including outreach, providing transportation. Staff are given the opportunity to attend trainings provided by internal partners, such as the Non-Communicable Disease Unit's Diabetes' Management Training, Dengue, Basic Life Support, COVID 19 presentations, COVID 19 swabbing and contact tracing. Staff were also trained on the Minimal Initial Service package for services during emergencies.
A TA training was provided to the MCH program manager and Finance people on the financial forms. Staff are also given the opportunity to attend off island trainings and webinars. WHO provides funding for Midwifery training in Fiji.

In 2020, RMI MCH staff members took part in the following activities:
Title X Family Planning call, Webinars, UNFPA calls, UNICEF, World Bank zoom calls,
The program staff was not able to attend any off-island trainings due to the Pandemic.

The need to build and improve the workforce for sustainability of the public health programs is imperative to improving delivery of services to the community. The shortage of local manpower impacts health service delivery in that there is a need to recruit manpower from the other countries, with a lengthy process and a high cost package compared to local hire, since housing is provided. The program will work closely with leadership to develop competent, committed and compassionate MCH professionals.

III.E.2.b.ii. Family Partnership

The MCH Program not only partners with internal and external programs, but is striving to involve families at all levels, individually, and at the decision- making level. Family/consumer engagement is needed in advisory committees, strategic and program planning, quality improvement, workforce development, block grant development and review, materials development, and advocacy. In order to ensure that services are effectively meeting the needs of the local population, programs under the MCH have taken a collective approach towards involving families in programmatic decision making. The program in collaboration with Human Services and EHDI program involved Parents in working groups as well as play groups. This gives opportunity for parents to come together and share experiences with autistic children and children with hearing problem. One of the focuses is for training and capacity building among families as a means for strengthening meaningful family engagement.

Parent As Teachers (PAT) was established by Women United Together in the Marshall Islands (WUTMI) in 2016. Focus groups with various target groups continue to be conducted.

In 2016, the MOHHS contracted Marshall Islands Epidemiology Initiative to facilitate focus groups with adolescents from RMI high schools. The focus groups were conducted with the intent to ensure that strategic and program planning are guided by family/consumer input. Surveys were also conducted throughout the communities. Moreover, for materials development, programs seek input from families who actively participate in MCH programs on items such as program brochures. Program informational materials, including those specific for the adolescent population, are reviewed by the health promotion division at the Ministry of Health and Human Services and approved by them prior to printing and distribution to the community as a mechanism for ensuring that print materials are culturally and linguistically appropriate. RMI kicked off with partnership with families group discussions concerning health of their children and will in the future engage families in decision making level.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

Under the Office of Health Planning, Policy, Preparedness and Epidemiology, MCH Program receives the needed support on the data review, capacity, monitoring and address maternal and child health issues. MCH Program is not able to get its own Epidemiologist, but we have the Ministry's Epidemiologist that we work with. There are also staff trained under Data Decision Making Course that received Diploma for Field Epidemiology and pursuing to continue to become certified Epidemiologist. Health Informatics Director and Deputy Secretary of OHPPPE have received their Diploma for Field Epidemiology.

There is 1 Epidemiologist funded CDC Epidemiology and Laboratory Capacity Grant that assist us in our MCH data capacity. Currently, she is remotely working with us because of RMI closure of borders. Although CDC funds the staff, MCH Block Grant and SSDI funds the meetings and trainings.

Due to the pandemic, most of our staff are tasked to assist the preparedness and response to ensure that RMI develops and implements RMI COVID-19 Response Plan. There was a plan in 2020 to enroll new cohort for Data Decision Making which will include the MCH Program Director but was deferred because of the current situation.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

SSDI's support to MCH Block Grant

The MOHHS has an office dedicated for building data capacity, assessment, planning, implementation and reporting which work in all the bureaus of SSDI program is under the Office of Health Planning, Policy, Preparedness and Epidemiology which makes it as an advantage to link all the activities in MCH Program. SSDI Director who is also the Health Informatics Director (used to known as IT Director) handles the MCH program information systems. For the past years, we have been building the IT infrastructure and data systems to be able to respond to the needs of MCH Program. SSDI program has been supporting the MCH Program in the annual submission of application and reports.

SSDI funded staff two Data Encoders. One is assigned in Vital Statistics Office who provided great assistance in keeping the Vital Statistics up to date from a 2 years back log of data entry, filling and submission. Data encoder also visit Ebeye Hospital and selected Outer Islands Health Centers to audit the birth and death occurrence. Daily visit to Majuro Hospital Medical Records and Maternity Ward for the registration of births and deaths. Coordinate with Outer Islands Health Care Services Main Office in Majuro for the weekly call to all 52 working health centers for birth and death occurrence. Work with the 177 Health Care Program Mission Coordinator for the birth and deaths occurrence in the 4 health centers under the program. With the funded staff, the Vital Statistics Office submitted fetal, birth and death certificates to Ministry of Culture and Internal Affairs for the certification of these registrations.

SSDI : **(12/1/2017 – 11/20/2022)**

Goal 1: Build and expand jurisdiction MCH data capacity to support the Title V MCH Block Grant program activities and contribute to data-driven decision making in MCH programs, including assessment, planning, implementation, and evaluation

- Supported the data needs of the Title V MCH Block Grant Application and Annual Report yearly submission
- Building capacity of the MCH Program and stakeholders to improve the needs assessment process. Update of the 2016-2020 Five Years Needs Assessment including progress, challenges and new strategies.
- Revision and improvement in the development, implementation, evaluation and monitoring of the National Outcome Measures (NOMs), National Performance Measures (NPMs), State Performance Measures (SPMs) and Evidence-informed Strategy Measures (ESMs)
- Support the MCH program needs in building its data infrastructure and information system

Goal 2: Provide partnership and on-site support for the development and implementation of a data collection tool/process that will enable tracking of Title V MCH Block Grant NPM data

Goal 2: Provide partnership and on-site support for the development and implementation of a data collection tool/process that will enable tracking of Title V MCH Block Grant NPM data

- Working with NORC on the development and implementation of Jurisdiction MCH Survey.

With the SSDI support in funding and technical assistance, the department continue to release the RMI Key Performance Indictors

The RMI Ministry of Health and Human Services (MOHHS) is responsible for improving the health status of the

people of the Republic of the Marshall Islands. It is essential to guide this effort with accurate, consistently measured, valid data, organized system in a way that gives a clear picture of both progress and problem areas.
Criteria for inclusion in the revised key performance indicator (KPI) set included:

- Give a balanced picture of the top health priorities of MOHHS and RMI;
- Summarize overall progress rather than programmatic details;
- Use internationally recommended health and performance indicators where possible so that comparisons can be made across countries;
- Are feasible to measure without great difficulty in the RMI.

The final set includes 36 indicators which fall into the following categories: demographics, non-communicable diseases, maternal & child health, infectious diseases, resource and administrative indicators. The KPIs were chosen to match priorities contained within the 3-year RMI MOHHS Strategic Plan (2018-2020) and designed to incorporate, where possible, indicators that are in harmony with RMI health sector commitments to the United Nations Strategic Development Goals and the Pacific Healthy Islands Framework. The intended target audience for KPI report includes the MOHHS Senior Leadership Team, Government of RMI, and partners like HRSA, CDC, WHO, SPC, and PIHOA

SSDI funding is instrumental in building RMI's MCH data capacity. As we are expanding addressing the data linkage of different silo systems, we need more resources to enhance our systems and ensure health equity and address the health disparity.

At this time of the pandemic, staff funded under SSDI were given additional roles and responsibilities which includes review of documents of fishing vessels, carriers and containers request to enter Majuro Seaport, support the administrative staff for processing of procurements, and data entry of COVID-19 testings. RMI COVID-19 Dashboards with information on the repatriation, sea and airport surveillance are developed and released under the department.

Because of the pandemic, IT consultants are unable to come and assist us in implementing the different modules under MHIS (Marshall Health Information System). Pending systems for development and implementation are Vital Records Information System and Milestones for 0-4 years old under the MCH Program. These activities are deferred to 2021.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

As the Ministry of Health and Human Services build its health information system, MCH related systems that addressed the data needs of MCH State Priorities are included and prioritized for 2021. With the plans for the MHIS (Marshall Health Information System), Outer Islands Health Centers will be able to access the systems with the improvement of communication systems in each health center. Telehealth Program is plan in the end of 2021.

The following systems are in development stage in 2021:

1. Vital Records Information System (birth and death linkage)
2. Milestones Module for 0-4 yrs old
3. Children with Special Health Care Needs Registry with link to their encounters with the providers

We also plan to assist MCH Block Grant in Performance and Quality Improvement Initiatives driven data and workforce capacity building.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

III.e.2.b.iv Emergency Planning/preparedness

It is important that MCH populations and staff be aware of what to do in emergency situations. MCH staffs need to be knowledgeable about state-level emergency preparedness plans and their roles in times of crisis. State-level MCH programs should consider what information is available and how to best share it with vulnerable populations.

The MCH program want to make sure that the needs of MCH populations are adequately addressed within state planning and address any gaps that may exist. State MCH staffs are also challenged to educate the families and individuals they work with about how to prepare for, respond to and recover from an emergency situation. Engaging in agency-specific planning and training are a first line of defense in preparing for a possible emergency. It is also vital to build relationships, if they do not already exist, with essential partners and those groups that are most vulnerable during an emergency.

MCH program and Family planning program in collaboration with UNFPA conducted a training on minimal Initial Service package to health workers. The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in crisis situations is a series of lifesaving activities required to respond to the SRH needs of affected populations during humanitarian crisis. These needs are often overlooked with potentially life-threatening consequences.

UNFPA leads the implementation of the MISP to ensure that all affected and vulnerable populations have access to lifesaving SRH services, especially during this COVID-19 environment. The aims of the implementation are that there is no unmet need for family planning, no preventable maternal deaths and no gender-based violence (GBV) or harmful practices, even during humanitarian crises.

The six objectives of MISP are:

1. Ensure the health sector or cluster identifies an organization to lead the implementation of the MISP

2. Prevent sexual violence and respond to the needs of survivors

3. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs

4. Prevent excess maternal and newborn morbidity and mortality

5. Prevent unintended pregnancies

6. Plan for comprehensive SRH services, integrated into PHC as soon as possible. Work with health

sector/ cluster partners to address the six-health system building blocks.

The Emergency planning and preparedness provides specific information about the various MCH groups and their specific needs during an emergency situation.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

RMI Health Care Service System

The Marshall Islands has a well-developed/organized primary/preventive and public health system. There are two main hospitals located in the two urbanized islands in the Kwajalein (Ebeye Hospital) and Majuro (Majuro Hospital) Atolls. Including the two main hospitals, there are 60 health centers/health clinics located in the various islands that make up the Marshall Islands. The two main hospitals serve the urban areas including the surrounding islands through referrals and medical evacuation. The two hospitals provide primary/secondary and some tertiary care. However, most tertiary care patients are referred off-islands to hospitals in the Philippines and Hawaii (Tripler Army Medical Center). In 2019, we have started referring patients to Republic of China-Taiwan. The health clinics in the Outer-Islands are staffed by Health Assistants who are locally trained and assigned to these clinics as primary care providers. The Marshall Islands MCH Title V program is one of the key programs in the Bureau of Primary Health Care Services and provides the mandated services for the MCH population.

The 177 Health Care Program (Victims of Nuclear Fallout of Bikini, Rongelap, Enewetak, and Utrik) Clinics provide primary health care services to the four atolls affected by the nuclear testing. A primary health care physician manages the 177 Clinics. The Department of Energy has a DOE Clinic which provides medical services to the direct nuclear patients. The Diabetes Wellness Center which is managed by Canvasback Missions, in collaboration with MOHHS, demonstrates that natural foods and an active lifestyle can reduce or replace the need for diabetic medications and provides a higher quality of life for the participants. They also offer healthy food options for minimal price. Taiwan Health Center concentrates on developing health education materials and training programs primarily used in Non-Communicable Diseases (NCDs) like diabetes and also helps with outreach activities, monthly missions on specialties to work at Majuro Hospital. Taiwan Health Center also work with Medical Education Committee for the internship of Medical Interns that graduated in Taiwan.

These health care services include, but are not limited to : a) clinical services in the hospitals and health center facilities and outreach activities; b) primary health care or preventive services in the hospital and health center settings, school and community compounds, house-to-house outreach; c) health promotions and educational activities, special projects with community groups; d) collection of data for the Health Information System to monitor health indicators, including monitoring and evaluation of health services and the health care systems.

In addition to the above-mentioned government sponsored health care services, there is one private health clinic and 1 private optometry practices in Majuro. All of the doctors practicing in the government and private clinics are licensed under the MOHHS' Medical Examining and Licensing Board to practice in the RMI including the medical and dental missions.

Medical Referral is handled by the Medical Referral Office. MCH program coordinated the CSHCN referral with Medical Referral Office. RMI has a national health insurance offering basic and supplemental health insurance. For Basic insurance, patient pays a) $5 for full outpatient visit which includes laboratory, diagnostics and pharmacy b) $17 for Emergency visit and c) $10 for admission. For patient with no insurance, patient pays a) $20 for full outpatient visit which includes laboratory, diagnostics and pharmacy b) $35 for Emergency visit and c) $110 for admission. To be able to receive basic referral where patients are referred to tertiary hospitals in Hawaii, Manila, and Taiwan, patients' needs to be enrolled in Basic Insurance. All Marshallese citizens are automatically under the Basic Insurance. For foreigners living and working in RMI, they need be an active member of Marshall Islands Social Security Administration with regular payment for 1 year and existing legal immigration papers.

Traditional Medicine Committee – This is a new committee created in 2019 by the cabinet to study and approve the

use of traditional medicine as part of the medicine formulary.

COVID-19 Preparedness and Response

The Secretary of Health and Human Services immediately acted upon the threat of 2019-nCOV diseases in January 2020. As of 24 January 2020, a travel alert was released for any traveler with travel originating from or transiting through the People's Republic of China must spend at least 14 days in a country not affected by 2019-nCoV. In the event a traveler arrives in RMI within the 14 day period, entry will be denied. Screening at the airport included the symptoms 2019-nCOV. By January 31, RMI close it air and sea borders to people coming from all COVID-19 countries. With this quick and definitive decision, RMI is still COVID-19 free. President David Kabua proclaimed State of Emergency due to the Global Public Health Emergency of International Concern on the COVID-19 on the 7th of February 2020.

Ministry of Health and Human Services Responsibilities on this proclamation:

- Activation of the MoHHS' Emergency Operations Plan (EOP) and Emergency Operations Center (EOC).
- Activation of the MOHHS' Epidemiology Network (EPINET) Team, the subject matter experts and focal point, will be charged with providing strategic direction, situational reports and advice on the MoHHS Communicable Disease Response Plan (CDRP) to the NDC on a daily and weekly basis or as needed.
- Implement surveillance protocols at all ports of entry on a daily basis.
- That the MoHHS CDRP will be activated and managed by the MoHHS EPINET Team with coordination with the NDC.
- Shall provide updates to the NDC, Cabinet and the general public on the international and local status of the nCoV.
- Advise the NDC and the Cabinet on relevant and sound recommendations including changes to the existing Travel Advisory due to the nCoV, extension and lifting of this Proclamation.

Preparedness Activities that are still on-going:
Infrastructure: Building and Renovation to retrofit for COVID-19 prevention and response needs:

- COVID-19 Isolation Unit
- PCR-Laboratories on Majuro Hospital and Ebeye Hospital
- Dengue ward that will be converted to COVID-19 Ward

Current/On-going projects:

- Labor and Delivery Repair
- Maternity Ward for COVID-19
- Warehouse
- Fencing of the whole Hospital
- Railing/roofing ; old building roofing
- Crisis Holding Unit for Human Services (Mental Health patients)
- Solar street lights & parking
- 3 additional central air con

Trainings:

- PPE Trainings/hand-washings
- Infection Control and Prevention
- Ventilator's training
- Isolation trainings and simulations
- Numerous lectures (locally and on-lines) on covid-19
- Waste management

Surge Staffing:

- Prepositioned Staff – Staff will be included in the repatriation trips
- Molecular Laboratory Scientists
- Lab Administrative Assistants (2) for Majuro and Ebeye
- Lab Serologists (2) for Majuro and Ebeye
- Surveillance Staff for Majuro and Ebeye
- Epidemiologists (2) for Majuro and Ebeye
- Nurses and doctors for Majuro and Ebeye have been identified and are being prepared for transport to RMI.
- Respiratory Therapists
- Biomedical Engineers
- Public Health Nurses

Due to the closure of borders and contract processing, there is a huge delay in hiring and repatriation of surge staff. As of the end of 2020, we have opened the posts and in the process of reviewing and interviewing.

MCH Clinics including Prenatal, Family Planning, Children's Clinics and other Public Health Programs developed its COVID-19 condition category plan. Once we are on condition three, RH/FP clinics are closed. But known pregnant patients will be given appointments and services will be provided. For new patients, they will be screened at ER and referred to the program. Labor and Delivery and Maternity Wards will be renovated to accommodate known or suspected COVID-19 patients.

In 2021, we are developing plans for TeleHealth Program that will address the remote consultations where COVID-19 community transmission is present.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

RMI don't have Medicaid services. We have our own local insurance.

III.E.2.c State Action Plan Narrative by Domain

State Action Plan Introduction

Adolescent Health Annual Plan

Population Domain: Adolescent Health
Priority Need: Teen reproductive health and pregnancy prevention.

SPM 4 Increase use of Family planning services to teenagers ages 13 to 17 years old

Objective: Increase use of Family planning services between 13 - 17 yrs old by 5% yearly.
Strategies:

- Community awareness of Family Planning Services through radio, print, social media platforms and participate in women and youth to youth conferences
    - Planning Program will utilize the FP IEC (Information, Education and Communication) Committee to revise old FP IEC materials and create new IEC in Marshallese, English and Chinese language.
    - MCH Program will fund the production for the radio, print, video and social media postings.
    - FP program will participate in the annual Women Conference, Youth to Youth Conference and Faith Based Conferences.

- Work with the community and women's group for family planning awareness and education.
    - MCH Program to provide funding for Women's group that will assist in the community awareness and education
    - Women's Group will assist in patient navigation to the FP services

- Strengthen the Family Planning Services at the Youth to Youth in Health Clinic and after dark clinic
    - FP services will still be available in Youth to Youth in Health and after dark clinic in Majuro. Clinic starts at 5:30 PM to 7:00 PM, Monday and Friday. The target population is the youth and patients that can't come to the FP clinic during regular clinic hours.
    - MCH program will sponsor at least 1 Youth awareness activity that will discuss Family Planning Services and annual check up visits. We will also include other youth-oriented programs in the Ministry on the awareness activity.

- Continue to provide family planning clinical services in Majuro, Ebeye and Outer Islands.
    - Program will ensure that FP commodities are available in all FP clinics and health centers in the Outer Islands.
    - Schedule community outreach and referral system
    - MCH Staff to continue providing regular FP services training to the Health Assistants in the Outer Islands

- Family Planning commodities and counseling training to MCH nurses, Family Planning nurses and School Nurses
    - With partnership with UNFPA, MCH Program will support the Family Planning commodities and

counselling training 2018-2019. The training for school nurses will build capacity to provide FP services in the schools.

Priority Need: Child Oral Health Program partnership with schools

NPM 13.2 Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives: By 2025, increased preventive dental care services for adolescent 15-17 yrs old by 5% yearly

Strategies:

- Strengthen partnership with Public School System for dental services availability in public school
  - Ensure dental services outreach school schedule is regularly updated and submitted to Public School System
  - At the beginning of the school year, Ministry of Health and Human Services Public Health programs meet with the PTAs for awareness of PH services offered in the school.
- Conduct community/school awareness of proper oral hygiene.
  - Develop IEC Oral Health materials that are translated into Marshallese and other common languages in RMI
  - Conduct community and school oral health awareness activities
  - Engage different platforms to disseminate IEC materials like social media posting, newspaper advertisement, radio spots and school bulletin boards.

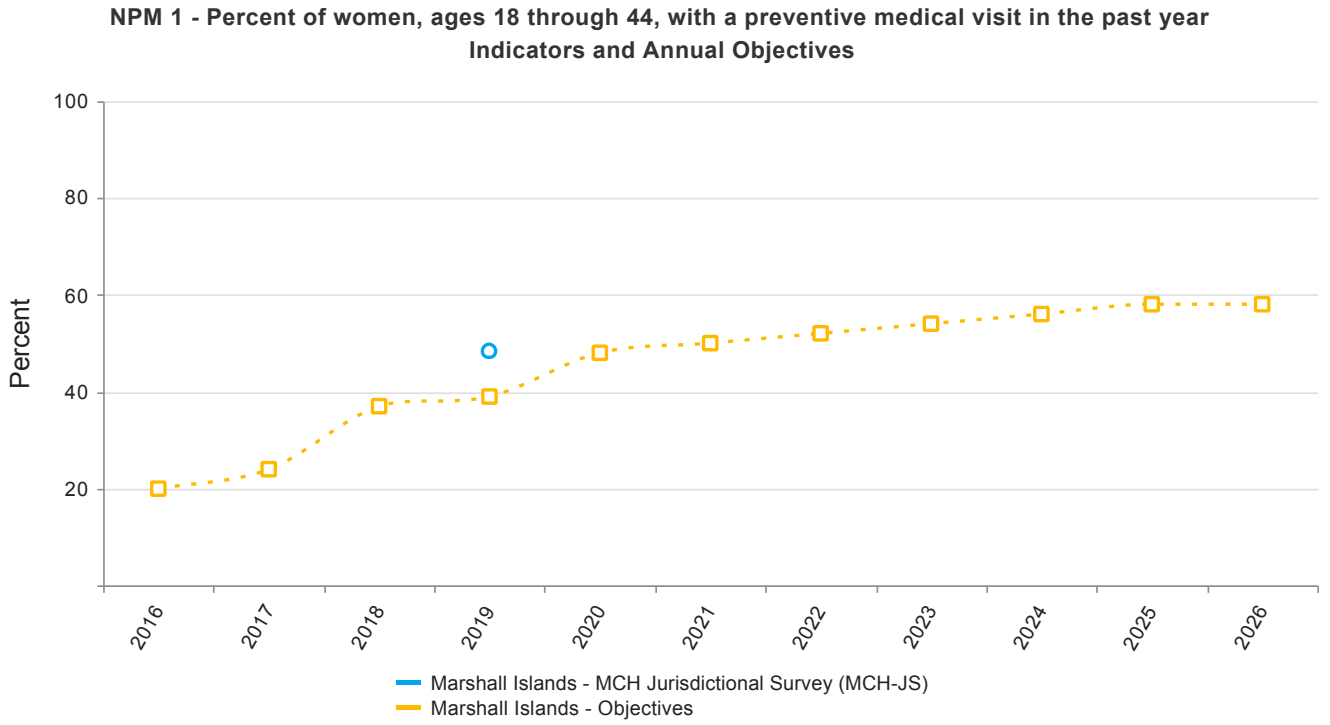
RMI will continue the activities in 2022. Due to COVID-19 pandemic poreparedness and response, activities were deferred.

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID	Data Not Available or Not Reportable	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	MCH-JS-2019	9.8 %	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	MCH-JS-2019	21.5 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2019	26.4	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2019	15.3	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS	Data Not Available or Not Reportable	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID	Data Not Available or Not Reportable	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	MCH-JS	Data Not Available or Not Reportable	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS	Data Not Available or Not Reportable	NPM 1

National Performance Measures



Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective		48
Annual Indicator	48.3	48.3
Numerator	8,951	8,951
Denominator	18,513	18,513
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	20	24	37	39	48
Annual Indicator	21.7	35.4	37.7		
Numerator	2,150	3,605	3,733		
Denominator	9,891	10,197	9,896		
Data Source	MCH Program	MCH Program	MCH Program		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	52.0	54.0	56.0	58.0	58.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	15.0	20.0	25.0	30.0	30.0

ESM 1.2 - Number of community health centers that provide cancer screening/referrals for women

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.0	2.0	3.0	3.0	5.0	5.0

ESM 1.3 - Percent of women booked for prenatal visit in first trimester

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	22.0	24.0	26.0	28.0	30.0

ESM 1.4 - Percent of women receiving postpartum follow-up health care services within the first four to six weeks after delivery.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	12.0	14.0	16.0	18.0	20.0

State Performance Measures

SPM 1 - Percent of Women ages 25-49 yrs old screened for cervical cancer.

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective	20	11	13	13
Annual Indicator	10.3	10.9	13.4	10.8
Numerator	828	856	892	917
Denominator	8,009	7,849	6,644	8,529
Data Source	MCH Program	MCH Program	MCH Progam	MCH Program
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	12.0	14.0	16.0	18.0	20.0	22.0

SPM 2 - Percent of women ages 15-44 years old that use family planning services

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective	16	18	20	16
Annual Indicator	15.5	16.8	14.5	11
Numerator	1,825	1,984	1,773	1,353
Denominator	11,773	11,790	12,255	12,271
Data Source	Family Planning Program	Family Planning Program	Family Planning Program	Family Planning Program
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	15.0	16.0	17.0	18.0	19.0	20.0

SPM 3 - Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			37	33
Annual Indicator			31.1	34.9
Numerator			372	359
Denominator			1,198	1,028
Data Source			MCH Program	MCH Program
Data Source Year			2019	2020
Provisional or Final ?			Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	35.0	37.0	39.0	41.0	43.0	43.0

State Action Plan Table

State Action Plan Table (Marshall Islands) - Women/Maternal Health - Entry 1	
Priority Need	
Access to coordinated, comprehensive care and services for Women before, during and after pregnancy	
NPM	
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
By July 2025, increase the percentage of women ages 18 through 44 who had a preventive medical visit in the past year to 58% (Baseline: 2019 MCH Jurisdictional Survey data 48.3%)]	
Strategies	
Promote well-woman visit through health education, awareness and campaign.	
Continued partnership with Cancer Program, HIV/STI Program and other Public Health programs	
Development and implementation of comprehensive one-stop shop well-woman essential services	
Strengthen Prenatal and post partum services	
ESMs	**Status**
ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year.	Active
ESM 1.2 - Number of community health centers that provide cancer screening/referrals for women	Active
ESM 1.3 - Percent of women booked for prenatal visit in first trimester	Active
ESM 1.4 - Percent of women receiving postpartum follow-up health care services within the first four to six weeks after delivery.	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (Marshall Islands) - Women/Maternal Health - Entry 2

Priority Need

Cancer screening and services for Women’s Health

SPM

SPM 1 - Percent of Women ages 25-49 yrs old screened for cervical cancer.

Objectives

By July 2025, increase in cervical cancer screening for ages 25-49 years old to 22% (Baseline: 2019 MCH Program - 13.4%)

Strategies

Continued partnership with cancer program in screening awareness and navigation of women to the women's health clinic

Increase availability of community health centers that provides cancer screening

State Action Plan Table (Marshall Islands) - Women/Maternal Health - Entry 3

Priority Need

Access to coordinated, comprehensive care and services for Women before, during and after pregnancy

SPM

SPM 2 - Percent of women ages 15-44 years old that use family planning services

Objectives

Increase percentage of women ages 15-44 years old that use family planning services by 5% yearly.

Strategies

Increase public awareness of the Family Planning Services

Continue the after 5 pm Family Planning Clinic .

Improve distribution and inventory of Family Planning commodities to all health centers.

Partnership with Women based NGOs that will provide health education and navigating of women to the Family Planning Services

State Action Plan Table (Marshall Islands) - Women/Maternal Health - Entry 4

Priority Need

Access to coordinated, comprehensive care and services for Women before, during and after pregnancy

SPM

SPM 3 - Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy

Objectives

Increase number of pregnant women with prenatal visits in the First Trimester of pregnancy by 5% yearly.

Strategies

Increase awareness and health education on benefits of prenatal visits through radio, print, social media and partnership with NGOs

Collaborate with Immunization Zone Nurses to refer pregnant women to Prenatal Clinic

Implement incentive program for pregnant women that attended Prenatal Clinic at the First Trimester

Improve HIV/STI screening for pregnant women using rapid test kits.

Women/Maternal Health Annual Report

NPM 1: Percent of women with a past year preventive medical visit

NPM 1: Percent of women with a past year preventive medical visit

Annual Objective	2016	2017	2018	2019	2020
Annual Indicator	21.7	35.4	37.7	48.3	48.3
Numerator	2,150	3,085	3,733	8,951	8,951
Denominator	9,891	10,197	9,896	18,513	18,513
Data Source	MCH Program	MCH Program	MCH Program	MCH-JS	MCH-JS
Data Source Year	2016	2017	2018	2019	2019

Priority Needs: Improve women/maternal health through cancer screening, prenatal services and family planning services

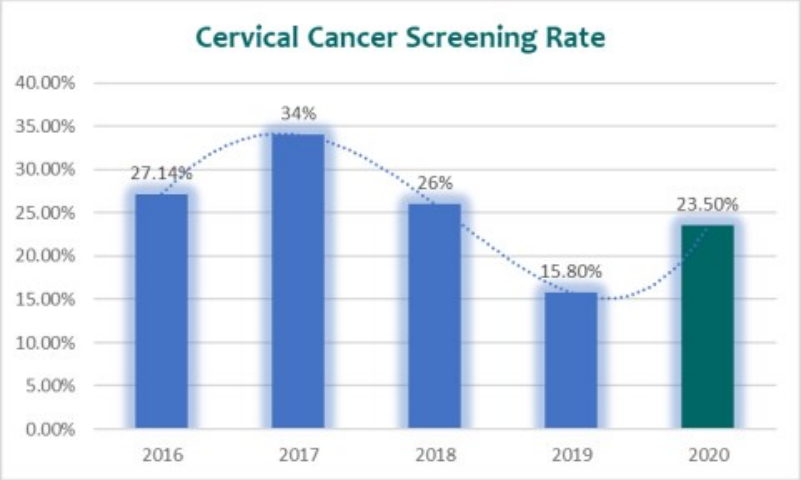
Strategy: Outreach mobile visits by MCH and FP Program to at least 6 Outer Islands yearly.

The program was able to visit 14 atolls to provide cervical cancer screening, breast exam and family planning services to the hard to reach population in the remote islands. These activities were implemented in collaboration with other public health programs which include STI/HIV, NCD(Diabetes and Hypertension), Immunization and dental. Family planning clients are provided with counselling and methods desired as well as cervical cancer screening and basic prenatal care to pregnant mothers. Program also conducted one on one counselling on the availability and importance of annual check ups, spacing of pregnancy as well as early prenatal care. High risk pregnant mothers and women with abnormal results are referred to Majuro for further examination and care . There is a challenge in the number of women seeking services with myths associated with family planning methods and fear of getting screened and knowing their results. Transportation is also a barrier to women seeking services.

Strategy: Partnership with Cancer Program in reaching out to bring women in the community and faith-based organization to avail the services of MCH program.

MCH Program partnership with Cancer program resulted in improvement of services. With this partnership, MCH Block Grant supports the staff and supplies to carry out the cervical cancer screening and breast cancer screening. Cancer Program contracted the services of WUTMI (Women United together Marshall Islands) to facilitate the schedule and assistance of bringing the women in the community and faith based organization in the MCH Clinics. Community awareness

RMI Goal: Increase cervical cancer screening rate to 60% by June 2022.

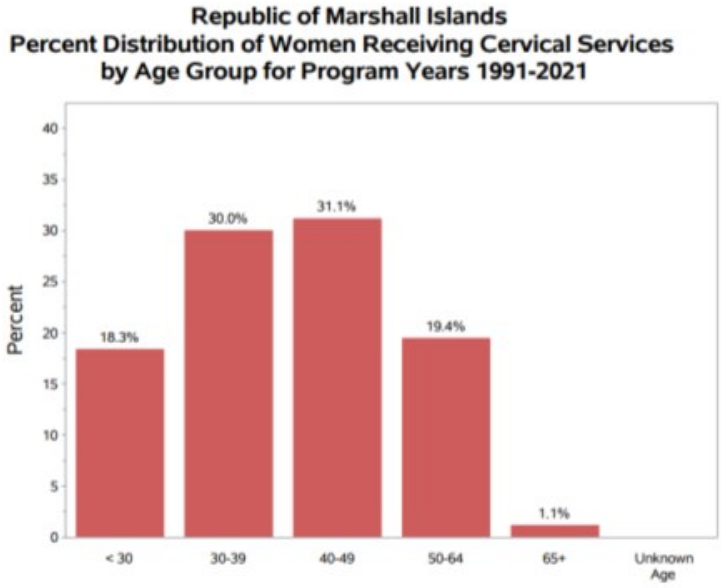


Data Source: Annual Chart Reviews using Uniform Data Systems Method
Note: Data only includes Pap Smear Testing (VIA excluded)

Decreased screening in 2018 and 2019 is attributed to lack of Canvasback Mission on OB-GYN. There are women that don't want to come to the clinics to be seen by our staff OB-GYNs because they are embarrassed. They opted to wait for an off-island mission because they will not see the doctors again. The OB-GYNs and MCH nurses are addressing this challenge by health education and counselling the women on patient confidentiality and trust.

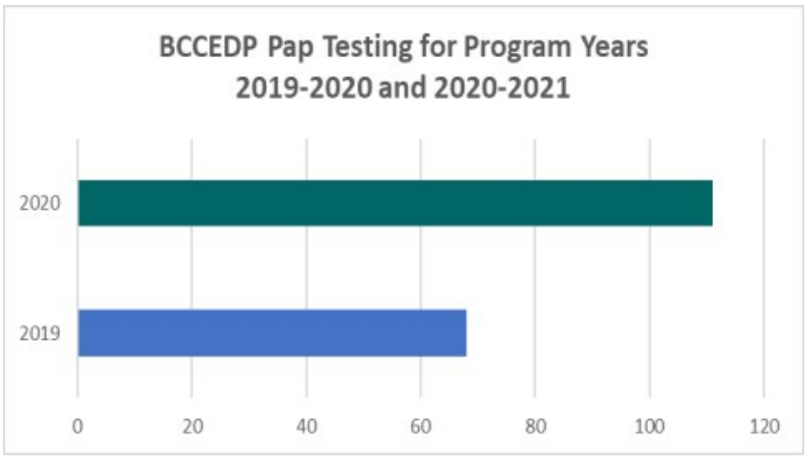
Back in 2004-2009 (5-year period), the average cervical cancer screening rate in RMI was just 12%. Right now, from 2016-2020 (5-year period), the average cervical cancer screening rate is at 25.3%. **It has more than doubled! Thanks to our providers and supporters!**

Increased cervical cancer screening in 2020 is attributed to increased After-Hours- Clinic screening services of the CDC-funded BCC Program.



Total number of women receiving cervical services with services paid by NBCCEDP funds = 180
Note: Age of woman based on first cervical service record with services paid by NBCCEDP funds
Source: April 2021 Minimum Data Elements for cervical served records through 12/31/2020 with services paid by NBCCEDP funds

Compared to the U.S, RMI
is screening more younger women (below 40 years old) but less older women (50-64 years old). This means that we are successful in trying to screen more younger women.



*BCCDEP - Breast Cervical Cancer Early Detection Program

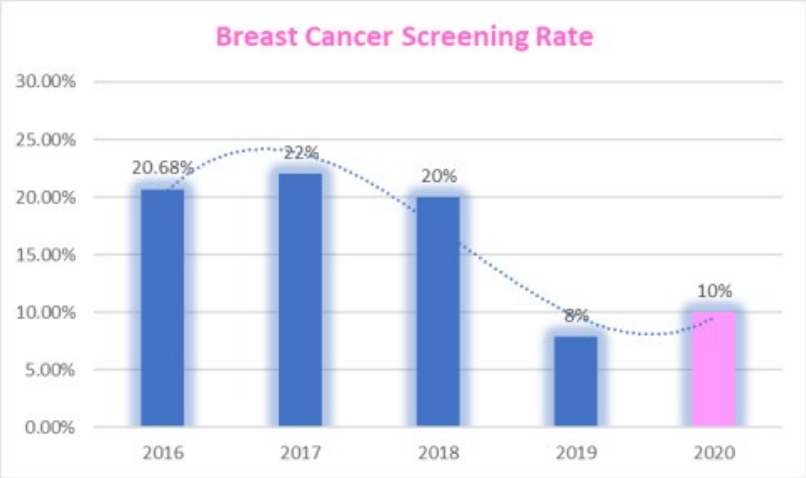
Breast and Cervical Cancer Program's After-Hours Clinic cervical cancer screening increased by 63%!

RMI Goal: Increase breast cancer screening rate to 30% by June 2022.

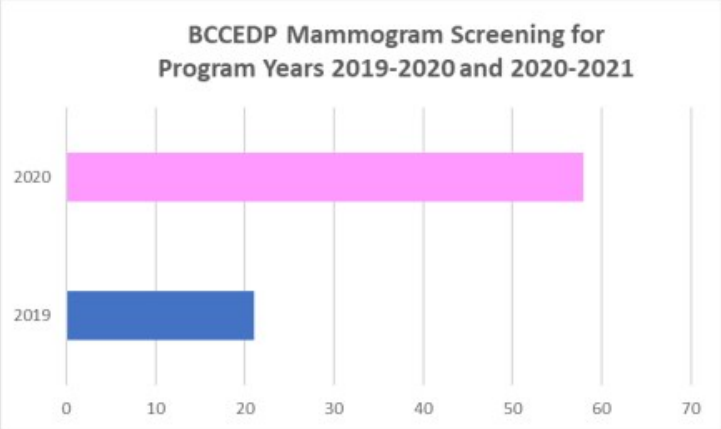
Back in 2004-2009 (5-year period), breast cancer screening rate in RMI was almost insignificant. Right now, from 2016-2020 (5-year period), the average cervical cancer screening rate is at 16%!

Thanks to our providers and acquisition of mammography units!

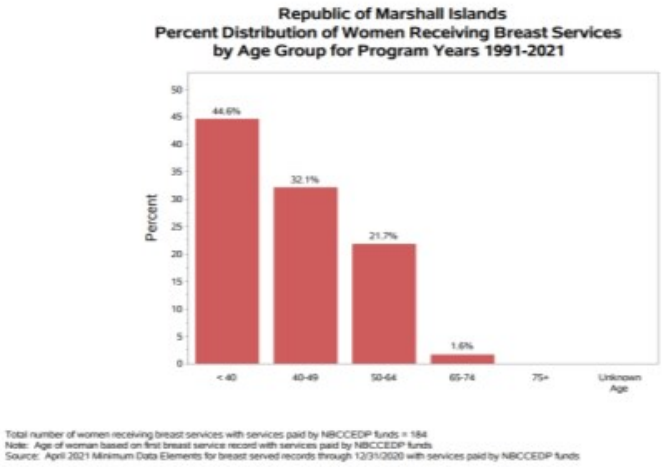
Sadly, one of our units is down for 2 years now and needs to be repaired!



Decreased screening in 2019 and 2020 is mainly due to broken mammogram machine. We can't bring experts to repair the mammogram machine because of the closure of our bordes due to COVID-19 pandemic.



More than 5% of breast mammograms done in 2019-2021 in the After-Hours Clinic is indicative of breast cancer!



Compared to the U.S. where screening is higher in older women than younger women, RMI breast cancer screening is higher in younger women (below 40 years old) but less in older women (50-64 years old).

ESM 1.2: Percentage of pregnant women who had at least 4 prenatal visits

Year	2016	2017	2018	2019	2020
Annual Indicator	88.3	66.1	66.8	64	44.8%

In 2020, MCH Program advertised the Prenatal Clinics schedule in the MOHHS FB page, newspaper and local radio station. Challenges for low turnout of pregnant women meeting at least 4 prenatal visits are coming in to the clinic at the third trimester, pregnant women that don't have enough money for transportation and lack of knowledge.

ESM 1.3: Percent of women ages 18 thru 44 seen at outreach mobile visits

In 2020, there were 449 women aged 18 to 44 years old that were seen during Outer Islands outreach mobile visits. In the outreach mobile visits, comprehensive public health services like prenatal checkups, family planning counselling, cancer screening, immunization, dental checkups, diabetes and hypertension screening, STI duo testing, TB screening and Leprosy Screening.

ESM 1.4: Number of pregnant women with dental check up

53% of pregnant women were given a dental check up in 2020. Dental services are highly in demand in RMI. We have a limited number of dentists to cater to pregnant women, children and other populations.

Women/Maternal Health Annual Plan

As the MCH program continues to improve its services for women and maternal health, we also want to reward women that takes ownership of improving their own health. In this application year, we will create an incentive program to those who will meet the criteria. In example, for pregnant women that attended prenatal clinic on her 1st trimester, Majuro Hospital to waive hospital fee after delivery. We will continue to strengthen our collaborations with our partnership in providing comprehensive services.

NPM 1 Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Priority : Access to coordinated, comprehensive care and services for Women before, during and after pregnancy

By July 2025, increase the percentage of women ages 18 through 44 who had a preventive medical visit in the past year to 58% (Baseline: 2019 MCH Jurisdictional Survey data 48.3%)]

Strategies

- Promote well-woman visit through health education, awareness and campaign
  - Create effective IEC materials translated to Marshallese and other common languages in RMI.
  - Partner with Women based NGOs to promote the availability of services for well-woman visit in the two main hospitals.
  - Sponsor activities on the Breast and Cervical cancer awareness.
- Continued partnership with Cancer Program, HIV/STI Program and other Public Health programs
  - MCH will continue the regular meetings with the Public Health Programs to consolidate and coordinate the activities especially with limited staffing and resources
  - Conduct quality assurance meetings to discuss the issues like supplies, schedules and other things that might affect the availability and delivery of services
- Development and implementation of comprehensive one-stop shop well-woman essential services
  - Develop a one stop shop well woman essential services where in available services
  - Create and implement SOP for this one-stop shop well-woman essential services
  - Partner or contract Patient Navigator to implement his strategy,
  - With the Senior Leadership, identify and develop a community health center that provide cancer screening and community referrals.
- Strengthen Prenatal and post partum services
  - Make the prenatal clinics conducive for the pregnant women
  - Implement regular post partum clinic schedule
  - Patient navigator or Nursing Staff to visit the pregnant women that missed her appointments.

ESMs	Status
ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year.	Active
ESM 1.2 - Number of community health centers that provide cancer screening/referrals for women	Active
ESM 1.3 - Percent of women booked for prenatal visit in first trimester	Active
ESM 1.4 - Percent of women receiving postpartum follow-up health care services within the first four to six weeks after delivery.	

Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS	Data Not Available or Not Reportable	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2019	26.4	NPM 3 NPM 4
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2019	15.3	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS	Data Not Available or Not Reportable	NPM 4
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 3
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 4

National Performance Measures

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
Indicators and Annual Objectives

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator	0	0
Denominator	2	8
Data Source	MOHHS	Vital Records Information System
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	1.0	1.0	2.0	2.0	2.0

Evidence-Based or –Informed Strategy Measures

ESM 3.1 - Number of birthing hospitals re-designated with updated standard operating procedures

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.0	1.0	2.0	2.0	2.0	2.0

ESM 3.2 - Percent of birthing hospitals who complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	100.0	100.0	100.0	100.0	100.0

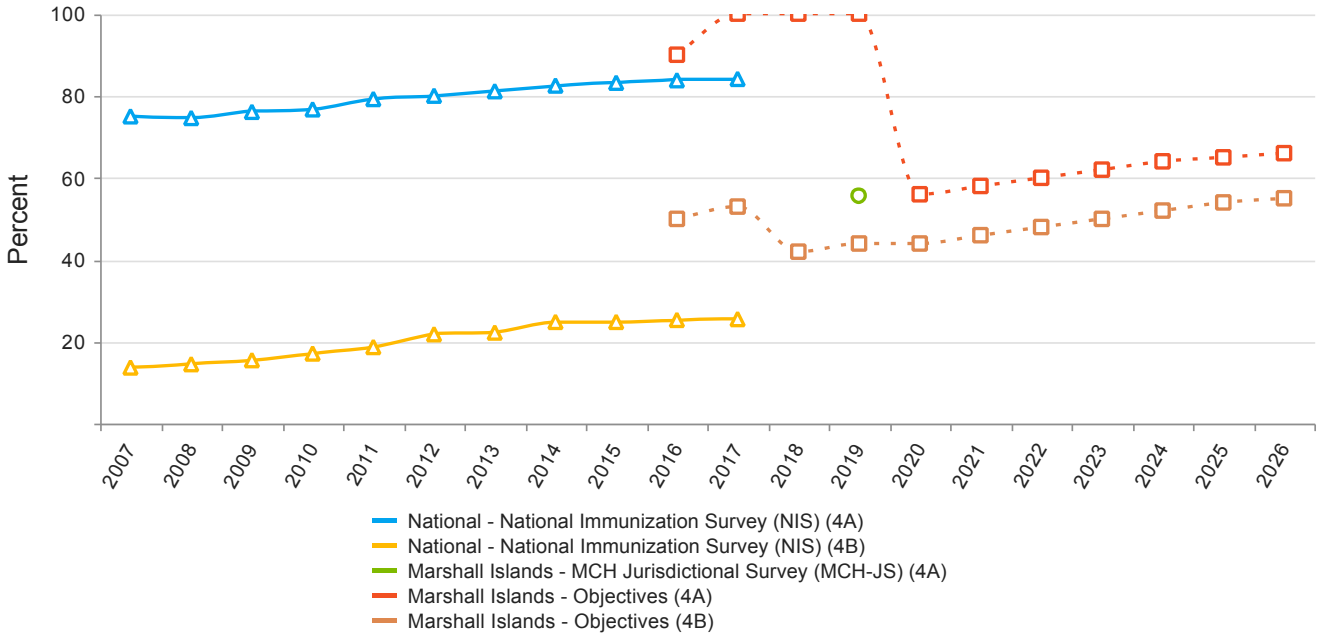
ESM 3.3 - Percent of newborn babies issued newborn baby health passbook

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	25.0	30.0	35.0	40.0	40.0

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	100	56
Annual Indicator	55.8	55.8
Numerator	5,143	5,143
Denominator	9,218	9,218
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	90	100	100	100	56
Annual Indicator	100	100	100		
Numerator	1,089	989	989		
Denominator	1,089	989	989		
Data Source	MCH Program	MCH Program	RMI ICHNS		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	58.0	60.0	62.0	64.0	65.0	66.0

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	50	53	42	44	44
Annual Indicator	50.3	40.5	42.3	42.3	42.3
Numerator	548	401	373	373	373
Denominator	1,089	989	881	881	881
Data Source	MCH Program	MCH Program	RMI ICHNS	RMI ICHNS	RMI ICHNS
Data Source Year	2016	2017	2018	2018	2018
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	46.0	48.0	50.0	52.0	54.0	55.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percent of women provided with in-person or telephonic breastfeeding consults/support services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 4.2 - Number of MCH staff and community health workers attended the Certified Lactation Counselor training.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	10.0	15.0	20.0	25.0	30.0

State Performance Measures

SPM 5 - Increase percentage of fully immunized children ages 19 to 35 months

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		48	50	63	65
Annual Indicator	46.1	46.8	61.3	64.1	58.6
Numerator	868	795	995	1,014	954
Denominator	1,881	1,697	1,624	1,583	1,629
Data Source	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	65.0	67.0	69.0	70.0	72.0	72.0

State Action Plan Table

State Action Plan Table (Marshall Islands) - Perinatal/Infant Health - Entry 1	
Priority Need	
Infants breastfed exclusively through six months	
NPM	
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	
Objectives	
By July 2025, increase the percent of infants who are ever breastfed to 65% (Baseline: 2019 MCH JS 55.8%)	
By July 2025, increase the percent of infants breastfed exclusively through 6 months to 54% (Baseline: 2018 RMI ICHNS 42.3%)	
Strategies	
Strengthen workforce capacity to provide breastfeeding education and counselling.	
Partner with community-based organizations to promote and support breastfeeding	
ESMs	**Status**
ESM 4.1 - Percent of women provided with in-person or telephonic breastfeeding consults/support services	Active
ESM 4.2 - Number of MCH staff and community health workers attended the Certified Lactation Counselor training.	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

State Action Plan Table (Marshall Islands) - Perinatal/Infant Health - Entry 2

Priority Need

Reduce infant mortality rate

NPM

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Objectives

By July 2025, reduce infant mortality rate by 5% yearly (Baseline: 2108 - 27.4 Per 1,000 live births)

Strategies

Improve the capability and capacity of the birthing hospital to handle critical newborns.

Update and implement birthing hospitals SOP for delivery and management of newborns

ESMs	Status
ESM 3.1 - Number of birthing hospitals re-designated with updated standard operating procedures	Active
ESM 3.2 - Percent of birthing hospitals who complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually	Active
ESM 3.3 - Percent of newborn babies issued newborn baby health passbook	Active

NOMs

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Perinatal/Infant Health Annual Report

Improve perinatal/infant's health through adequate and quality prenatal services and newborn screening

MCH Block Grant Program works closely with EHDI Program. Collaboration of work and alignment of plans are engaged to ensure that both programs don't duplicate work but able to support the needs of Infant Health.

Early Hearing Detection & Intervention (EHDI) Program

2020	MAJURO	EBEYE	TOTAL	SCREENING (%'s)	
BIRTHS	681	266	947	MAJURO	100%
Screened	670	261	931	EBEYE	98%
Missed	0	2	2		
Deceased	11	3	14		
Evaluation in Process	6	1	7		
Diagnosed Hearing			0		
Loss	-	-	-		
Referred to EI	-	-	-		
EI Caseload	9	4	13		

Early Intervention is provided to all babies who have been identified with a hearing loss/deafness. These families get home visits once a week and join a playgroup also once a week. Families on Ebeye only receive weekly home visits.

Challenges

The greatest challenge has been the pandemic. The EHDI Program requires routine visits by a Pediatric Audiologist to travel to the RMI, both Majuro and Ebeye to conduct Diagnostic Evaluations on babies who failed their initial hearing screening tests. These audiological visits take place three to four times a year. Because of the pandemic the nation has been forced to close the borders EHDI program had to cancel all scheduled audiological visits for the entire year. A pediatric ENT was scheduled to travel here in June to conduct hands on training to the newly hired ENT which has been canceled due to the pandemic. With cancellation of routine visits by the itinerant audiologist, babies who failed the newborn hearing screening do not get audiological diagnostic evaluations. These babies are at risk of having a hearing loss or deafness. Hearing Screening and diagnostic equipment need periodic calibrations. With the borders closed there is no way for the equipment to be calibrated since there is no specialist on island.

Accomplishments

A successful audiological visit was done in February 2020. The last one before the borders were closed. Intinerant ENT traveled to Ebeye and conducted surgeries, mainly PE (pressure equalizing) tubes as well as tympanoplasty for ages under 17. Donated medical supplies to Ebeye Operating Room in February. Hired a local EI provider after the

deaf world teachers went back home to the States. Conducted training for early intervention for the local provider. Trained all the doctors on Ebeye to use the otocam (camera otoscope) to take pictures of the inner ear and share with off island ENT

Ways forward. Set up tele-audiology and tele-intervention capabilities

Perinatal/Prenatal Services

Having healthy infants are linked to the good health of the mothers. In 2019, MCH program with clinical advisor provided trainings in improvement of prenatal services, to Maternity and Labor and Delivery wards. Standardizing the clinical guidelines to be able to improve health care given to the mother and infant

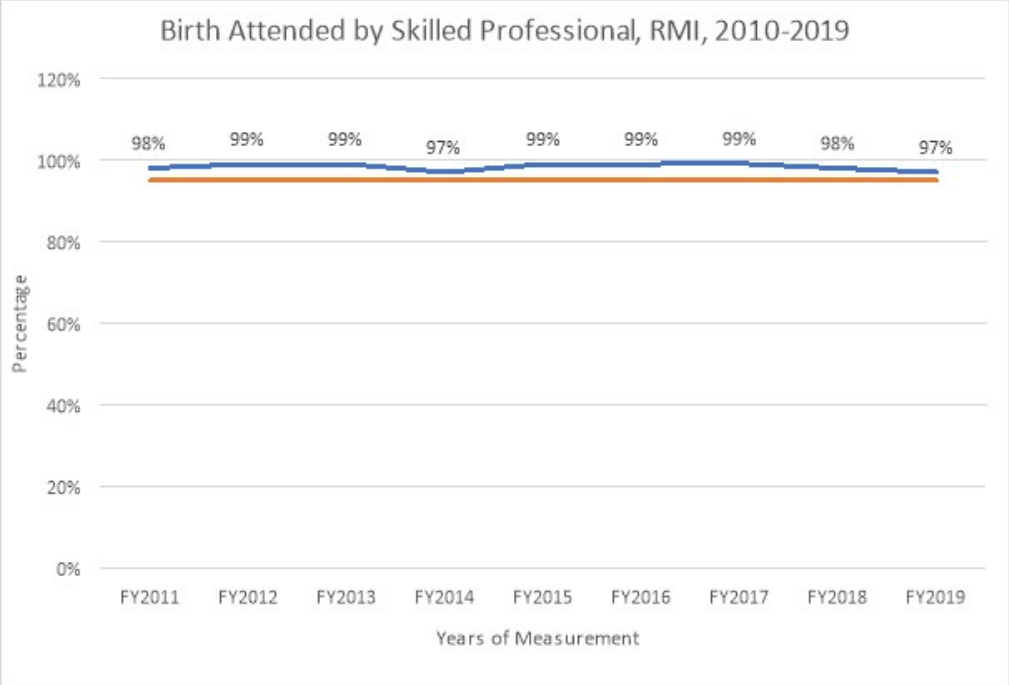
Prenatal care services are available in the 2 main hospitals and all 60 health centers. In the health centers, service is limited wherein tests that needs laboratory confirmation are not available.

ESM 1.2 - Percentage of pregnant women who had at least 4 prenatal visits

	2017	2018	2019	2020
Annual Objective	90	68	69	70
Annual Indictor	66.1	66.8	64	44.8
Numerator	654	661	627	461
Denominator	989	989	980	1,028
Data Source	MCH Program	MCH Program	MCH Program	MCH Program

Ensure every woman has skilled professional at delivery

97% of births in 2019 are delivered by skilled attendants like nurse, midwife, health assistant, medical assistant and doctors. In childbearing, women need a continuum of care to ensure the best possible health outcome for them and their newborns. This includes care at the clinic before and after delivery, as well as high quality midwifery care at delivery. The risk of stillbirth and maternal deaths is reduced by about 20% with the presence of a skilled birth attendant.



Infant Health

20 per 1,000 live births died in 2020 before they reach the age of 1 yr. old. Prematurity, aspiration, and pneumonia, congenital defects are the most common underlying causes of death for these infants which is the same as in 2019. This stresses the importance of Early prenatal care and good management skills during labor. The importance of Exclusive breastfeeding up to 6 months is part of the counselling services at the RH clinic, maternity ward and the postnatal clinic. With the Early Childhood Development (ECD) program in place, there are plans to have BF class to pregnant mothers by a nutritionist and a trained lactation nurse. Lactation nurse will trained staff from maternity, labor and delivery and pediatric wards. But due to the closure of borders and challenge in hiring new staff, Lactation Nurse was not hired in 2020. ECD Program will still continue to provide the support.

In 2019, RMI conducted survey on child health and nutrition for 0-5 yrs old. Below is the result on breastfeeding and infant feeding,

Breastfeeding and infant feeding			
MICS Indicator	**Indicator**	**Description**	**Value**
2.5	Children ever breastfed	Percentage of women with a live birth in the last 2 years who breastfed their last live-born child at any time	87.4
2.6	Early initiation of breastfeeding	Percentage of women with a live birth in the last 2 years who put their last newborn to the breast within one hour of birth	60.8
2.7	Exclusive breastfeeding under 6 months	Percentage of infants under 6 months of age who are exclusively breastfed[4]	42.3
2.8	Predominant breastfeeding under 6 months	Percentage of infants under 6 months of age who received breast milk as the predominant source of nourishment [5] during the previous day	50.9
2.9	Continued breastfeeding at 1 year	Percentage of children age 12-15 months who received breast milk during the previous day	40.5
2.10	Continued breastfeeding at 2 years	Percentage of children age 20-23 months who received breast milk during the previous day	34.2
2.12	Age-appropriate breastfeeding	Percentage of children age 0-23 months appropriately fed [6] during the previous day	39.8
2.13	Introduction of solid, semi-solid or soft foods	Percentage of infants age 6-8 months who received solid, semi-solid or soft foods during the previous day	64.2
2.14	Milk feeding frequency for non-breastfed children	Percentage of non-breastfed children age 6-23 months who received at least 2 milk feedings during the previous day	39.4
2.15	Minimum meal frequency	Percentage of children age 6-23 months who received solid, semi-solid and soft foods (plus milk feeds for non-breastfed children) the minimum number of times or more [7] during the previous day	60.8

MCH Program is actively advocating breastfeeding inside and outside the hospitals. In the hospital, no bottle feeding is implemented but there are mothers that are not following the policy. During the MCH Workshop, the maternity nurses shared that Chinese women opted for bottle feeding than exclusive breastfeeding.

There are still children coming in with Malnutrition. One of the needs presented by the Pediatricians is to have a feeding program. This issue on the feeding program was discussed by the leadership team . With the ECD program in place, there is a plan to have cash transfers to families with low income to support purchase nutritious food

	2016	2017	2018	2019	2020
NPM 4 - A) Percent of infants who are ever breastfed	100	100	100	55.8*	55.8*
NPM 4 B) Percent of infants breastfed exclusively through 6	50.3	40.5	42.3	42.3	42.3**

*MCH JS

**Children and Nutrition Health Survey

NPM 4 A): Once the mothers give birth, the newborns are immediately breastfed. RMI practice First Embrace. First embrace is lifesaving skin to skin contact immediately after birth between the baby and the mother.

NPM 4- B) We need to strengthen our community awareness and data collection. We will be working with women's group to reach the women population and able to provide them health education on the remind them on the benefits of breastfeeding for their children.

Perinatal/Infant Health

MCH Program continues to support the improvement of services in prenatal and new born screening. In May 2018, HIV/STI Program implemented SD Bioline HIV/Syphilis Duo in partnership with MCH Program. Syphilis and HIV testing at the tip of your fingers. Result will come out 15-20 minutes. Availability of Chlamydia and Gonorrhea testing through GeneXpert. For 2 years, we were not able to perform Chlamydia and Gonorrhea testing because of logistics problem.

With the recent MCH Workshop, the team identified the need to improve the newborn screening. Currently, we can only provide new born hearing screening.

Priority: Infants breastfed exclusively through six months

NPM 4 A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objective:

- By July 2025, increase the percent of infants who are ever breastfed to 65% (Baseline: 2019 MCH JS 55.8%)
- By July 2025, increase the percent of infants breastfed exclusively through 6 months to 54% (Baseline: 2018 RMI ICHNS 42.3%)

Strategy:

- Strengthen workforce capacity to provide breastfeeding education and counselling.
  - Hire a lactation Nurse that will strengthen the breastfeeding capacity of the hospitals and the health centers
  - Lactation Nurse will train the staff in breastfeeding education and counselling
  - Develop the access of the workforce for proper breastfeeding tools and sites.

- Partner with community-based organizations to promote and support breastfeeding
  - Identify Women based NGOs that will assist us in promotion and campaign of breastfeeding
  - MCH Program will conduct at least 1 public awareness campaign during the Breastfeeding week.
  - During Women Conference, MCH Program will participate to promote and train women on proper breastfeeding. Program will use radio, print, and social media platforms to promote breastfeeding. Continue proving health education, promotion and demonstration to mothers on exclusive breastfeeding of infants up to 6 months, complimentary food at 6 months and to continue breastfeeding up to 2-3 years of life during their prenatal and well-baby clinic visit

Priority Need: Reduce infant mortality rate

NPM 3 Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Objective: By July 2025, reduce infant mortality rate by 5% yearly (Baseline: 2108 - 27.4 Per 1,000 live births)

Strategy:

- Improve the capability and capacity of the birthing hospital to handle critical newborns.
  - Complete the CDC Levels of Care Assessment Tool (CDC LOCATe)
  - Develop and implement work plan to address the result of the CDC LOCATe
  -
- Update and implement birthing hospitals SOP for delivery and management of newborns
  - Update SOPs for delivery and management of newborns
  - Training and implementation of the SOPs
  - Yearly evaluation of the SOPs

RMI will continue the activities in 2022. Due to COVID-19 pandemic poreparedness and response, activities were deferred.

Child Health

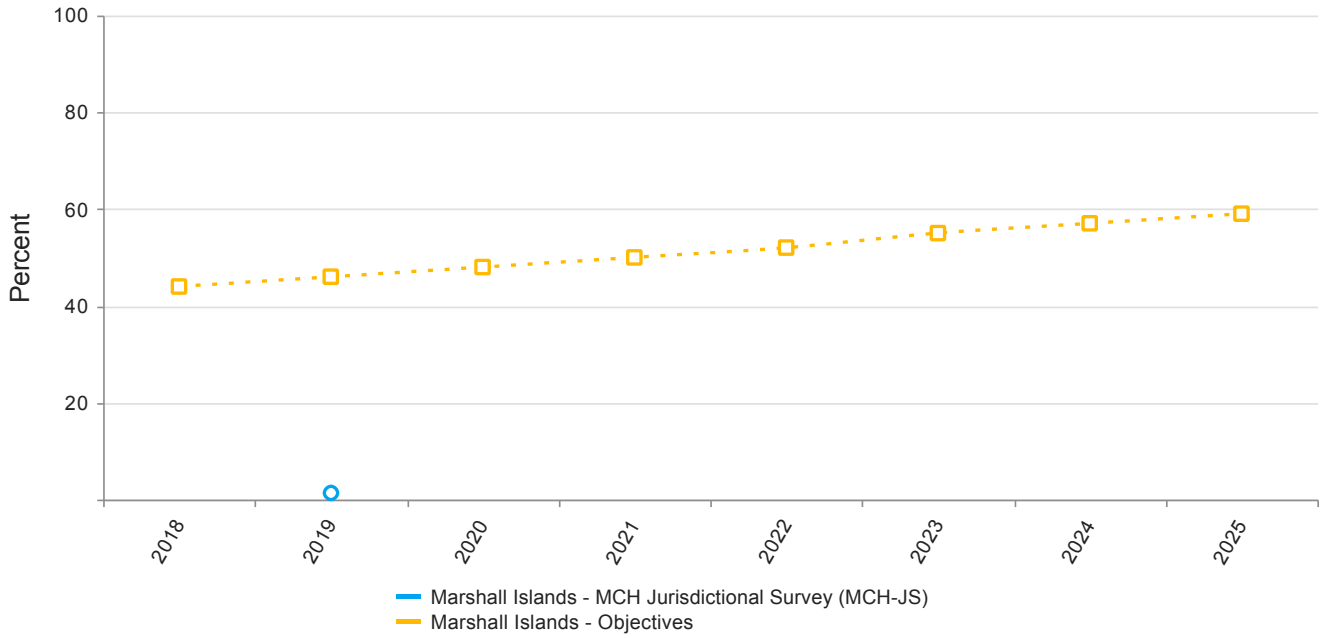
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	MCH-JS-2019	23.8 %	NPM 13.2
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH	Data Not Available or Not Reportable	NPM 13.2
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 7.1
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	MCH-JS-2019	0 %	NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	MCH-JS-2019	57.2 %	NPM 6 NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 6 NPM 13.2

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Indicators and Annual Objectives



Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	46	48
Annual Indicator	1.5	1.5
Numerator	53	53
Denominator	3,619	3,619
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			44	46	48
Annual Indicator	43.9	42.8	30.8		
Numerator	1,668	532	500		
Denominator	3,801	1,243	1,624		
Data Source	MCH Program	MCH Program	MCH Program		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Provisional	Provisional		

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	52.0	55.0	57.0	59.0	60.0

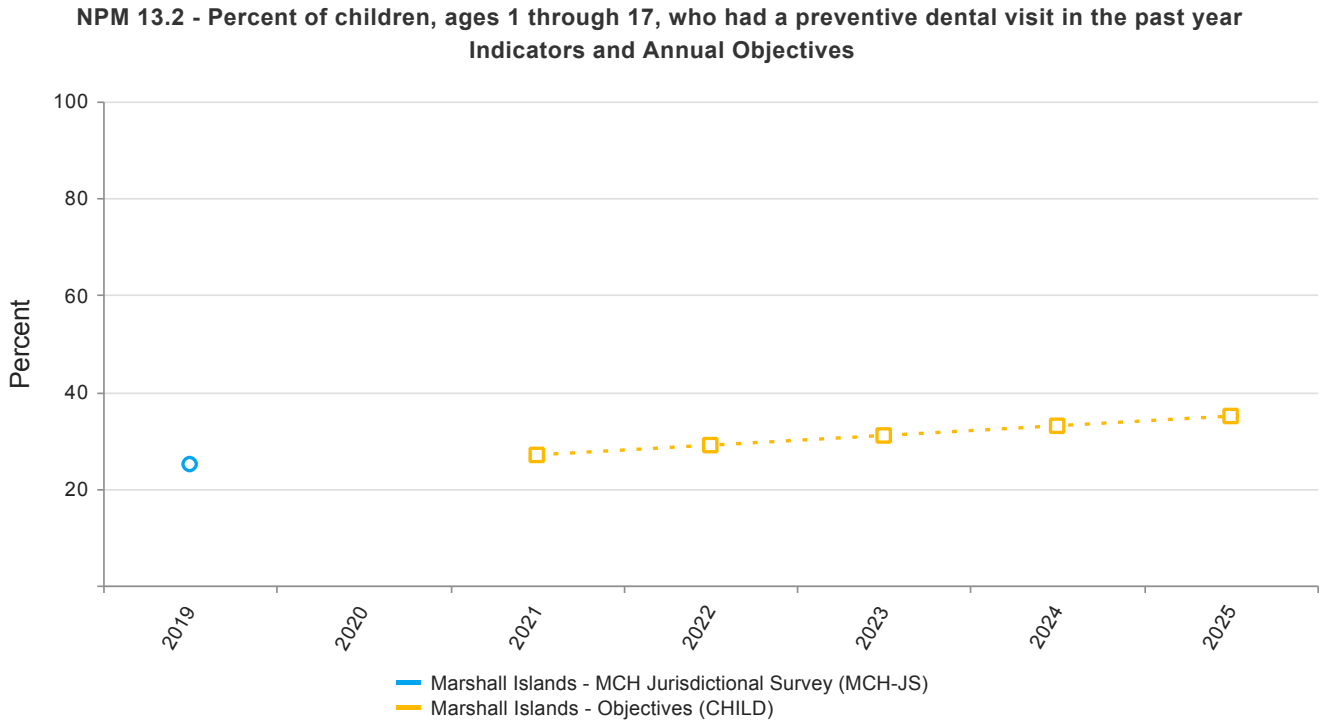
Evidence-Based or –Informed Strategy Measures

ESM 6.1 - The number of potential high risk screens referred to early intervention

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes



NPM 13.2 - Child Health

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective		
Annual Indicator	25.2	25.2
Numerator	5,835	5,835
Denominator	23,195	23,195
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	27.0	29.0	31.0	33.0	35.0	35.0

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Percentage of elementary schools visited by dental program

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		14.3
Numerator		16
Denominator		112
Data Source		Dental Clinics/MCH Program
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	15.0	17.0	19.0	21.0	22.0	24.0

ESM 13.2.2 - Number of children ages 1-17 years receiving preventive dental care from a dentist.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		20.9
Numerator		2,691
Denominator		12,889
Data Source		Dental Clinics/MCH Program
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	22.0	24.0	26.0	28.0	30.0

State Performance Measures

SPM 5 - Increase percentage of fully immunized children ages 19 to 35 months

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		48	50	63	65
Annual Indicator	46.1	46.8	61.3	64.1	58.6
Numerator	868	795	995	1,014	954
Denominator	1,881	1,697	1,624	1,583	1,629
Data Source	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	65.0	67.0	69.0	70.0	72.0	72.0

State Action Plan Table

State Action Plan Table (Marshall Islands) - Child Health - Entry 1	
Priority Need	
Parent-completed developmental screening tools	
NPM	
NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	
Objectives	
By 2025, increase in referral from clinics to CSHCN registry by using the developmental screening tools	
Strategies	
Implement the new well baby clinic standardized developmental tool in the two main hospitals and all the health centers.	
Implement data system to capture and monitor developmental screening information and referrals	
Create and distribute new baby passport where monitoring of developmental tools is included.	
ESMs	**Status**
ESM 6.1 - The number of potential high risk screens referred to early intervention	Active
NOMs	
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

State Action Plan Table (Marshall Islands) - Child Health - Entry 2

Priority Need

Child Oral Health Program partnership with schools

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

By 2025, increased number of children ages 1 to 14 years old with preventive dental care services by 5% yearly

Strategies

Increase campaign and awareness on oral health hygiene and available services.

Regular outreach mobile visits to the Outer Islands

ESMs	Status
ESM 13.2.1 - Percentage of elementary schools visited by dental program	Active
ESM 13.2.2 - Number of children ages 1-17 years receiving preventive dental care from a dentist.	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Marshall Islands) - Child Health - Entry 3

Priority Need

Parent-completed developmental screening tools

SPM

SPM 5 - Increase percentage of fully immunized children ages 19 to 35 months

Objectives

To increase immunization coverage for children 19 to 35 months old by 5% yearly

Strategies

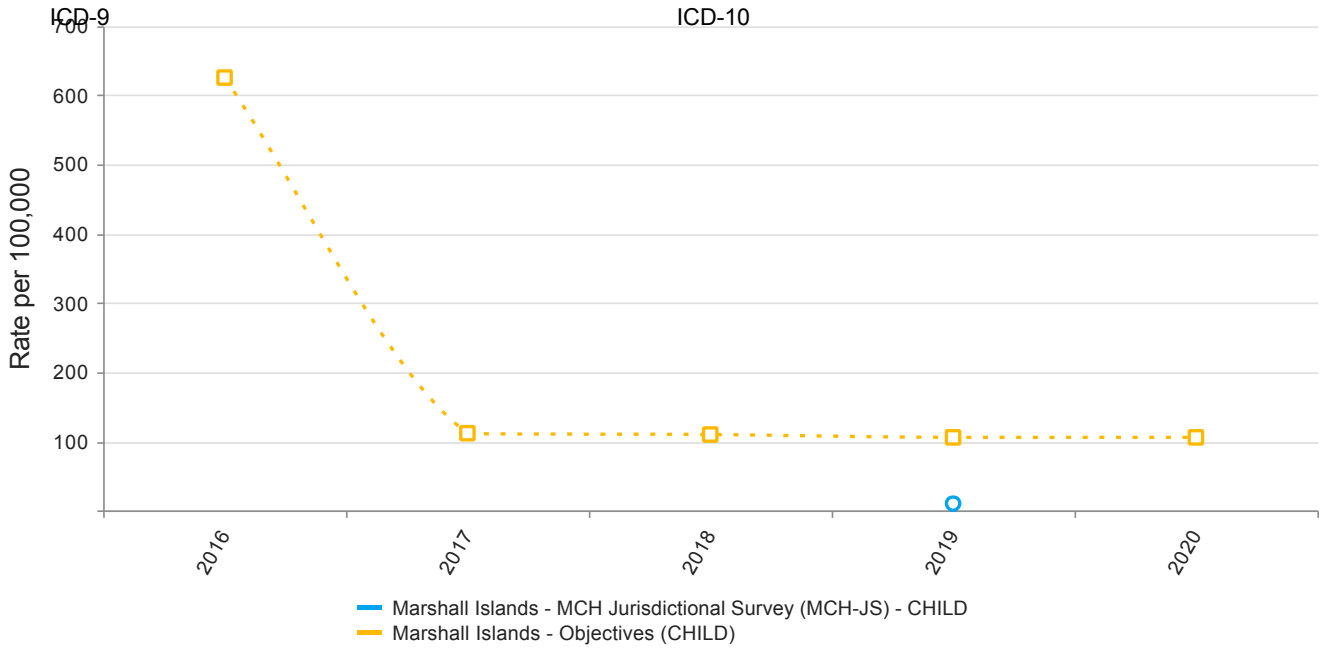
Continue to provide quality outreach mobile immunization visits to the Outer Islands

Conduct community awareness on the proper immunization schedule and the benefits of immunization

Continue to provide immunization services on Saturdays and outreach zone visits.

2016-2020: National Performance Measures

2016-2020: NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 Indicators and Annual Objectives



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CHILD		
	2019	**2020**
Annual Objective	106	106
Annual Indicator	10.9	10.9
Numerator	1,612	1,612
Denominator	14,760	14,760
Data Source	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	625	112	110	106	106
Annual Indicator	114.4	108.7	34.6		
Numerator	32	16	5		
Denominator	27,965	14,716	14,457		
Data Source	Hospital Database	Hospital Database	Hospital Database		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 7.1.1 - Number of community campaign on awareness and promotion of child safety within the community.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	3	3	1	3
Annual Indicator	0	0	0	33.3
Numerator	0	0	0	1
Denominator	3	3	3	3
Data Source	MCH Program	MCH Program	MCH Program	MCH Program
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Provisional

Child Health - Annual Report

Child Health Annual Report

With the COVID-19 Pandemic, most of our activities and meetings were deferred.

Priority Need: Improve child health through early childhood developmental screening, and complete vaccinations.

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

ESM 6.1 - Implement a Comprehensive Developmental Screening tool for 10 through 71 months children

A task force was created to develop and implement the milestone passbook that supports the data collection for ESM 6.1. There was a delay in 2020 due to the activities related to COVID-19 pandemic. Task force has drafted the milestone passbook with English and Marshallese version. It is ready for review. Aside from the passbook, electronic version of the passbook will be developed in MHIS (Marshall Health Information System) for data collection.

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19

	2016	2017	2018	2019*	2020*
Annual Objective	615	112	110	108	108
Annual Indicator	114.4	108.7	34.6	10.9	10.9
Numerator	32	16	5	1612	1612
Denominator	27,965	14,716	14,457	14,760	14,760

*MCH JS

2016 - Cause for hospitalization are burn, injury, suicide, MVA, and environmental accident.

2017: Cause of hospitalization: Burn, Fall, Drowning, Moving Vehicle Accident, hot liquid, injury.

2018 - Diagnosis for hospitalization are head injury, burn and MVA

Child injuries are preventable but we still continue to receive patients in the hospital. Community and families need to work together to make the environment safe for the children.

The Ministry of Public Safety continues to implement the following activities to support the promotion of child safety:

1. Seat Belt Law- There's a seat belt law but none for mandatory child car seat.
2. Police man assigned to each school during arrival and dismissal of students
3. Traffic stops when school bus stopped and wait for pick up or return the students from school to their designated area

	2016	2017	2018	2019	2020
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	59.3	68.6	53.4	38	65.8

In 2017, there are 68.6 per 100,000 children ages 1 to 9 yrs old. Underlying cause of death are: 2 to drowning, 1 vehicular accident, 1 laceration of the neck (murder), 3 malnutrition, 1 dehydration, 1 probable meningitis,

In 2018, Causes of death: Severe malnutrition: 1, Drowning: 2, MVA: 1, Septicemia: 2, Meningitis: 1

In 2019, Cause of death: Pneumonia: 3, Drowning: 1, Congenital Heart Disease: 1

In 2020, Cause of death: Accident (Drowning: 2, Fall from tree – 1): 3; Gastroenteritis: 2; Pneumonia : 2; Congenital Heart Disease: 1; Sepsis : 1

It is unfortunate that young children are dying of malnutrition and dehydration. We need to strengthen family and community support group. If a child in the community is malnourished, members of the community can refer them to MCH Program to be able to refer to the health care that the child needs.

SPM 2 - Final and endorsed readiness assessment of RMI MOHHS to handle Autism Spectrum Disorder, Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder Program

ESM 6.2 - Percentage of children diagnosed with ASD and ADHD

Under the Behavioral Health Clinic, Clinical Director and team strengthen the referral system of children with behavioral problem see in the Children's Clinic. Clinical Director provided the guidance and referral forms to ensure that the referral and transition of management is done properly.

Psychiatrist in Behavioral Health Clinic in Majuro developed a referral system with the Majuro Hospital Pediatricians for evaluation of children with behavioral and emotional disorder. Out of the 19 referred patients, there were 2 that meet the clinical diagnosis for ADHD

SPM 3 - Increase percentage of fully immunized children ages 19 to 35 months

The National Immunization Program continue to provide vaccination services. The RMI Immunization schedule is 4DTAP, 3HepB, 1HIB, 1MMR, 3IPV for 19-35 months. Immunization program had to visit 1 island for 4 times a year to be able to reach 90% immunization rate in the Outer Islands. This is an ideal situation where in the program is having difficulty to achieve due to challenge in air and sea transportation, staff and movement of population from island to island.

RMI Immunization Coverage Rate for children 19-35months (4DTAP, 3HepB, 1HIB, 3IPV, 1MMR

Islands	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	**FY2018**	**FY2019**	**FY2020**
Majuro	68%	55%	60%	53%	55%	41%	40.8%	61.2%	67.3%	63.9%
Kwajalein	99.70%	99%	99%	99%	99%	95%	89.2%	95.2%	95.5%	84.9%
Outer Islands	55%	32%	57%	34%	46%	23%	21.8%	25.6%	15.6%	17.1%
RMI	72%	53%	65%	55%	59%	47%	46.8%	61.3%	64.1%	58.6%

With the preparedness and response on COVID-19 Pandemic, the Immunization rate decreased by 6% in 2020. The Immunization team was unable to do meet their goal of atleast 2 Outreach mobile visits to the Outer Islands.

Below is the RMI Immunization schedule:

Recommended vaccination schedule for children 0-6 years, Republic of the Marshall Islands

Vaccine	Birth	2 mos.	4 mos.	6 mos.	12 mos.	15 mos.	4-6 years
BCG	1st Dose						
HepB	1st Dose	2nd Dose		3rd Dose			
DTaP		1st Dose	2nd Dose	3rd Dose	4th Dose		5th Dose
Polio		1st Dose	2nd Dose	3rd Dose			4th Dose
Hib		1st Dose	2nd Dose		3rd Dose		
PCV		1st Dose	2nd Dose	3rd Dose	4th Dose		
Rotavirus vaccine		1st Dose	2nd Dose	3rd Dose			
MMR					1st Dose	2nd Dose	

RMI Immunization Program received cold chain equipment from UNICEF to upgrade of the cold chain equipment. New cold chain equipment were distributed in the immunization depot in Majuro and Ebeye. The next project is to implement solar powered cold chain equipment in the Outer Islands Health Centers. With CDC funding, Immunization continues to provide vaccines in Majuro, Ebeye and Outer Islands. Program has zoning, house to house visit and outreach mobile visits.

Child Health - Application Year

Child Health Annual Report

With the COVID-19 Pandemic, most of our activities and meetings were deferred.

Priority Need: Improve child health through early childhood developmental screening, and complete vaccinations.

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

ESM 6.1 - Implement a Comprehensive Developmental Screening tool for 10 through 71 months children

A task force was created to develop and implement the milestone passbook that supports the data collection for ESM 6.1. There was a delay in 2020 due to the activities related to COVID-19 pandemic. Task force has drafted the milestone passbook with English and Marshallese version. It is ready for review. Aside from the passbook, electronic version of the passbook will be developed in MHIS (Marshall Health Information System) for data collection.

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19

	2016	2017	2018	2019*	2020*
Annual Objective	615	112	110	108	108
Annual Indicator	114.4	108.7	34.6	10.9	10.9
Numerator	32	16	5	1612	1612
Denominator	27,965	14,716	14,457	14,760	14,760

*MCH JS

2016 - Cause for hospitalization are burn, injury, suicide, MVA, and environmental accident.

2017: Cause of hospitalization: Burn, Fall, Drowning, Moving Vehicle Accident, hot liquid, injury.

2018 - Diagnosis for hospitalization are head injury, burn and MVA

Child injuries are preventable but we still continue to receive patients in the hospital. Community and families need to work together to make the environment safe for the children.

The Ministry of Public Safety continues to implement the following activities to support the promotion of child safety:

1. Seat Belt Law- There's a seat belt law but none for mandatory child car seat.
2. Police man assigned to each school during arrival and dismissal of students
3. Traffic stops when school bus stopped and wait for pick up or return the students from school to their designated area

	2016	2017	2018	2019	2020
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	59.3	68.6	53.4	38	65.8

In 2017, there are 68.6 per 100,000 children ages 1 to 9 yrs old. Underlying cause of death are: 2 to drowning, 1 vehicular accident, 1 laceration of the neck (murder), 3 malnutrition, 1 dehydration, 1 probable meningitis,

In 2018, Causes of death: Severe malnutrition: 1, Drowning: 2, MVA: 1, Septicemia: 2, Meningitis: 1

In 2019, Cause of death: Pneumonia: 3, Drowning: 1, Congenital Heart Disease: 1

In 2020, Cause of death: Accident (Drowning: 2, Fall from tree – 1): 3; Gastroenteritis: 2; Pneumonia : 2; Congenital Heart Disease: 1; Sepsis : 1

It is unfortunate that young children are dying of malnutrition and dehydration. We need to strengthen family and community support group. If a child in the community is malnourished, members of the community can refer them to MCH Program to be able to refer to the health care that the child needs.

SPM 2 - Final and endorsed readiness assessment of RMI MOHHS to handle Autism Spectrum Disorder, Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder Program

ESM 6.2 - Percentage of children diagnosed with ASD and ADHD

Under the Behavioral Health Clinic, Clinical Director and team strengthen the referral system of children with behavioral problem see in the Children's Clinic. Clinical Director provided the guidance and referral forms to ensure that the referral and transition of management is done properly.

Psychiatrist in Behavioral Health Clinic in Majuro developed a referral system with the Majuro Hospital Pediatricians for evaluation of children with behavioral and emotional disorder. Out of the 19 referred patients, there were 2 that meet the clinical diagnosis for ADHD

SPM 3 - Increase percentage of fully immunized children ages 19 to 35 months

The National Immunization Program continue to provide vaccination services. The RMI Immunization schedule is 4DTAP, 3HepB, 1HIB, 1MMR, 3IPV for 19-35 months. Immunization program had to visit 1 island for 4 times a year to be able to reach 90% immunization rate in the Outer Islands. This is an ideal situation where in the program is having difficulty to achieve due to challenge in air and sea transportation, staff and movement of population from island to island.

RMI Immunization Coverage Rate for children 19-35months (4DTAP, 3HepB, 1HIB, 3IPV, 1MMR

Islands	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	**FY2018**	**FY2019**	**FY2020**
Majuro	68%	55%	60%	53%	55%	41%	40.8%	61.2%	67.3%	63.9%
Kwajalein	99.70%	99%	99%	99%	99%	95%	89.2%	95.2%	95.5%	84.9%
Outer Islands	55%	32%	57%	34%	46%	23%	21.8%	25.6%	15.6%	17.1%
RMI	72%	53%	65%	55%	59%	47%	46.8%	61.3%	64.1%	58.6%

With the preparedness and response on COVID-19 Pandemic, the Immunization rate decreased by 6% in 2020. The Immunization team was unable to do meet their goal of atleast 2 Outreach mobile visits to the Outer Islands.

Below is the RMI Immunization schedule:

Recommended vaccination schedule for children 0-6 years, Republic of the Marshall Islands

Vaccine	Birth	2 mos.	4 mos.	6 mos.	12 mos.	15 mos.	4-6 years
BCG	1st Dose						
HepB	1st Dose	2nd Dose		3rd Dose			
DTaP		1st Dose	2nd Dose	3rd Dose	4th Dose		5th Dose
Polio		1st Dose	2nd Dose	3rd Dose			4th Dose
Hib		1st Dose	2nd Dose		3rd Dose		
PCV		1st Dose	2nd Dose	3rd Dose	4th Dose		
Rotavirus vaccine		1st Dose	2nd Dose	3rd Dose			
MMR					1st Dose	2nd Dose	

RMI Immunization Program received cold chain equipment from UNICEF to upgrade of the cold chain equipment. New cold chain equipment were distributed in the immunization depot in Majuro and Ebeye. The next project is to implement solar powered cold chain equipment in the Outer Islands Health Centers. With CDC funding, Immunization continues to provide vaccines in Majuro, Ebeye and Outer Islands. Program has zoning, house to house visit and outreach mobile visits.

Adolescent Health

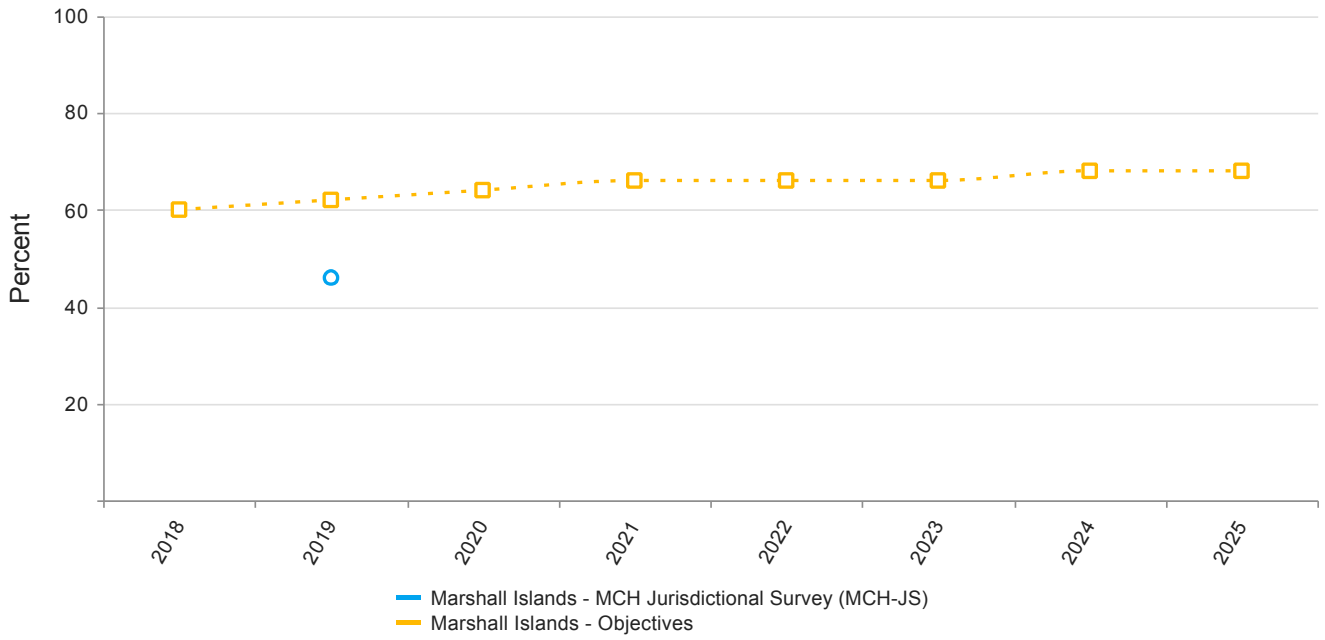
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	MCH-JS-2019	23.8 %	NPM 13.2
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH	Data Not Available or Not Reportable	NPM 13.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	MCH-JS-2019	0 %	NPM 10 NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 10 NPM 13.2
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	MCH-JS-2019	13.4 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	MCH-JS-2019	57.2 %	NPM 10 NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 10 NPM 13.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	MCH-JS-Age 0-2	Data Not Available or Not Reportable	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	MCH-JS-Age 10-17-2019	18.2 %	NPM 10

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC	Data Not Available or Not Reportable	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2007	24.9 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS	Data Not Available or Not Reportable	NPM 10

National Performance Measures

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Indicators and Annual Objectives



Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	62	64
Annual Indicator	45.9	45.9
Numerator	2,966	2,966
Denominator	6,465	6,465
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			60	62	64
Annual Indicator	17.2	61.4			
Numerator	1,375	4,943			
Denominator	7,978	8,045			
Data Source	Public Health Programs	Public Health Programs			
Data Source Year	2016	2017			
Provisional or Final ?	Final	Final	Final		

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	66.0	66.0	66.0	68.0	68.0	68.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	12.0	15.0	17.0	20.0	25.0

ESM 10.2 - Percent of public middle and high schools visited to deliver pregnancy & STI prevention program

Measure Status:	Active

Baseline data was not available/provided.

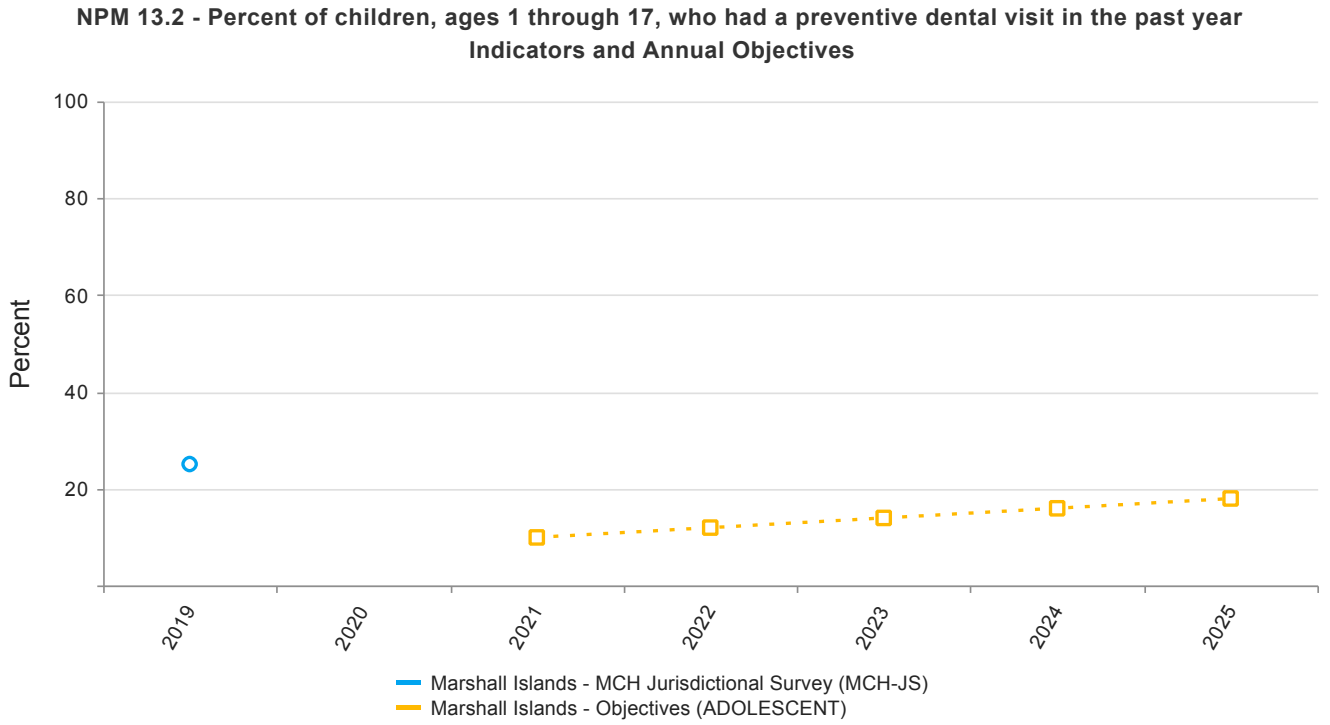
Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	10.0	15.0	20.0	25.0	30.0

ESM 10.3 - HPV vaccine coverage of girls age 13 years

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective	47	37	39	51
Annual Indicator	34.9	36.4	49	33.3
Numerator	230	245	351	206
Denominator	659	673	717	619
Data Source	WebIZ, Immunization Program	WebIZ, Immunization Program	WebIZ, Immunization Program	WebIZ, Immunization Program
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	35.0	36.0	37.0	38.0	39.0	40.0



NPM 13.2 - Adolescent Health

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective		
Annual Indicator	25.2	25.2
Numerator	5,835	5,835
Denominator	23,195	23,195
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	10.0	12.0	14.0	16.0	18.0	18.0

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Percentage of elementary schools visited by dental program

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		14.3
Numerator		16
Denominator		112
Data Source		Dental Clinics/MCH Program
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	15.0	17.0	19.0	21.0	22.0	24.0

ESM 13.2.2 - Number of children ages 1-17 years receiving preventive dental care from a dentist.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		20.9
Numerator		2,691
Denominator		12,889
Data Source		Dental Clinics/MCH Program
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	22.0	24.0	26.0	28.0	30.0

State Performance Measures

SPM 4 - Increase use of Family planning services to teenagers ages 13 to 17 years old

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective	10	20	20	13
Annual Indicator	18.6	18.8	11.8	21
Numerator	124	126	79	115
Denominator	6,650	6,686	6,686	5,464
Data Source	Family Planning Program	Family Planning Program	Family Planning Program	Family Planning Program
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	22.0	24.0	26.0	28.0	30.0	30.0

State Action Plan Table

State Action Plan Table (Marshall Islands) - Adolescent Health - Entry 1	
Priority Need	
Child Oral Health Program partnership with schools	
NPM	
NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	
Objectives	
By 2025, increased preventive dental care services for adolescent 15-17 yrs old by 5% yearly	
Strategies	
Strengthen partnership with Public School System for dental services availability in public school	
Conduct community/school awareness of proper oral hygiene.	
ESMs	**Status**
ESM 13.2.1 - Percentage of elementary schools visited by dental program	Active
ESM 13.2.2 - Number of children ages 1-17 years receiving preventive dental care from a dentist.	Active
NOMs	
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	

State Action Plan Table (Marshall Islands) - Adolescent Health - Entry 2

Priority Need

Improve adolescent health through promotion of adolescent well-being.

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

By 2025, increase HPV coverage rate for 13 years old female by 5% yearly or by 61 Per 1,000 13 yrs old female population.

Strategies

Make HPV Vaccination Routine Vaccine to 11-12 yrs old.
Strengthen HPV Vaccination messages to the community in partnership with Cancer Program
Conduct meetings with Parent and Teachers Association (PTAs) to provide awareness and health education on HPV vaccines and cervical cancer

ESMs	Status
ESM 10.1 - Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year	Active
ESM 10.2 - Percent of public middle and high schools visited to deliver pregnancy & STI prevention program	Active
ESM 10.3 - HPV vaccine coverage of girls age 13 years	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Marshall Islands) - Adolescent Health - Entry 3

Priority Need

Teen reproductive health and pregnancy prevention.

SPM

SPM 4 - Increase use of Family planning services to teenagers ages 13 to 17 years old

Objectives

Increase use of Family planning services between 13 - 17 yrs old by 5% yearly.

Strategies

Community awareness of Family Planning Services through radio, print, social media platforms and participate in women and youth to youth conferences

Work with the community and women's group for family planning awareness and education.

Strengthen the Family Planning Services at the Youth to Youth in Health Clinic and after dark clinic

Continue to provide family planning clinical services in Majuro, Ebeye and Outer Islands.

Family Planning commodities and counseling training to MCH nurses, Family Planning nurses and School Nurses

Adolescent Health Annual Report

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

In 2020, there were activities deferred due to the preparedness and response for COVID-19 Pandemic. We continue provide existing services to the adolescent population.

	2016	2017	2018	2019	2020
NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	17.2	61.4		45.9*	45.9*
Increase use of Family planning services to teenagers ages 13 to 17 years old (Rate per 1,000 Teenagers 13-17 yrs old.)		18.6	18.8	11.8	21
HPV vaccine coverage of girls age 13 years (%)		34.9	36.4	49	33.3
Adolescent mortality rate ages 10 through 19, per 100,000	76.6	51.5	103	112.5	86.6
Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	0	0	0	0	0
Adolescent suicide rate, ages 15 through 19, per 100,000	65	0	31.1	61.4	41.2
Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	37.2	21.2	40.7	49	40.3
Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	35.4	17	12.9	12.3	18.6
Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	28.8	13	12.9	15.9	15.3
Teen birth rate, ages 15 through 19, per 1,000 females	49	45	48.4	48.7	65.7

*MCH JS

Preventive medical visit services include Eye checkup, Stool and urine analysis, Immunization, TB Screening, Leprosy Screening and STI/HIV Screening. Due to limited and availability of complete services in the Outer Islands, preventive medical visit is only given in Majuro Hospital and Ebeye Hospital. Medical clearance is required for high school and college entry, food handlers, work clearance and immigration.

Adolescent mortality rate ages 10 through 19, per 100,000
In 2017, there are 7 deaths among ages 10 – 19 yrs old. Underlying cases of death are the following: 2 pneumonia, 1 Congestive Heart Failure, 1 Bacterial Meningitis, 1 Drowning, 1 Post extubation acute pulmonary edema, 2 unknown

In 2018, there are 14 deaths among ages 10 – 19 yrs old. Underlying cases of death are the following: Endometritis: 1, Malnutrition: 1, Suicide: 2, Maternal Death : 1, Cancer: 2, Pneumonia: 2, CNS infection: 1, Blood Byscrasia: 1. Bacterial Meningitis: 1, Sepsis: 1, RHD: 1, Drowning (boat coalition): 1

There are 2 suicide deaths who were both 19 yrs old male. The community supports activities like basketball games, volleyball games, drama plays, and school activities where in adolescent population are involved and given chance to excel. Behavioral Health staff are coming to the schools to provide health talks especially on stress on being a teenager, peer pressure and bullying.

In 2019, there are 3 adolescent suicide deaths due to hanging. Behavioral Health Department are engaged in providing suicide awareness activities in the schools and out of school youth. There is also an on-going drug addiction and selling in the community. This emerging problem is being addressed in the RMI Drug Task force composed of different government agencies and NGOs.

HPV vaccinations campaign was launched by Immunization Program headed by School Immunization Coordinator. Public School System supports the campaign and endorsed it to the public schools. There is only one school that resist the promotion and vaccination of HPV due religious reason. Immunization program partnered with Cancer Program and MCH Program to be able to reach the mothers that will provide consent for HPV vaccinations.

There are only 18.8 per 1,000 female ages 13 to 17 years old that has family planning services. We have to strengthen our activities and reach more teenagers which will eventually lower down our teen births which is 48.4 per 1,000 females ages 15-19 yrs old. Teen prevention pregnancy group continue to visit the high schools in Majuro, Ebeye and Outer Islands to provide presentations, counselling and distribution of condoms. MCH Program with partnership with HIV/STI Program created and implement the Sexual Reproductive Health curriculum to one of the private school. The trained students are able to provide SRH talk to other students. Students are more open and comfortable talking with the same age group.

Calculation of the Preventive visits includes: 12-17 yrs old that visits Immunization program for vaccination (Tdap, MCV, HPV), HIV/STI screening test, Family Planning services, and prenatal services for teen pregnancy.

In 2020, causes of death for 10-19 years old were 2 suicides by hanging, 2 Pneumonia, 1 TB, 1 vehicular accident, 1 Dengue, 1 Cancer, 1 Congenital disease, and 1 uncal herniation. There is no vehicular accident death on 15-19 yrs old.

SPM 4 - Increase use of Family planning services to teenagers ages 13 to 17 years old

	2016	2017	2018	2019	2020
Increase use of Family planning services to teenagers ages 13 to 17 years old (Rate per 1,000 Teenagers 13-17 yrs old.)		18.6	18.8	11.8	21

MCH Block Grant Program continue to provide staff and supplies for after hrs and Saturday clinics at the Youth to Youth in health. There is a low turnout because YTYIH administration lost their funding to support youth navigator to bring youths for consultation and family planning awareness.

MCH program partnered with STI/HIV Program to provide family planning counselling to the 13-17 years old that receive physical exam prior to school enrollment.

Adolescent Health Annual Plan

Population Domain: Adolescent Health
Priority Need: Teen reproductive health and pregnancy prevention.

SPM 4 Increase use of Family planning services to teenagers ages 13 to 17 years old

Objective: Increase use of Family planning services between 13 - 17 yrs old by 5% yearly.
Strategies:

- Community awareness of Family Planning Services through radio, print, social media platforms and participate in women and youth to youth conferences
    - Planning Program will utilize the FP IEC (Information, Education and Communication) Committee to revise old FP IEC materials and create new IEC in Marshallese, English and Chinese language.
    - MCH Program will fund the production for the radio, print, video and social media postings.
    - FP program will participate in the annual Women Conference, Youth to Youth Conference and Faith Based Conferences.

- Work with the community and women's group for family planning awareness and education.
    - MCH Program to provide funding for Women's group that will assist in the community awareness and education
    - Women's Group will assist in patient navigation to the FP services

- Strengthen the Family Planning Services at the Youth to Youth in Health Clinic and after dark clinic
    - FP services will still be available in Youth to Youth in Health and after dark clinic in Majuro. Clinic starts at 5:30 PM to 7:00 PM, Monday and Friday. The target population is the youth and patients that can't come to the FP clinic during regular clinic hours.
    - MCH program will sponsor at least 1 Youth awareness activity that will discuss Family Planning Services and annual check up visits. We will also include other youth-oriented programs in the Ministry on the awareness activity.

- Continue to provide family planning clinical services in Majuro, Ebeye and Outer Islands.
    - Program will ensure that FP commodities are available in all FP clinics and health centers in the Outer Islands.
    - Schedule community outreach and referral system
    - MCH Staff to continue providing regular FP services training to the Health Assistants in the Outer Islands

- Family Planning commodities and counseling training to MCH nurses, Family Planning nurses and School Nurses
    - With partnership with UNFPA, MCH Program will support the Family Planning commodities and counselling training 2018-2019. The training for school nurses will build capacity to provide FP services in the schools.

Priority Need: Child Oral Health Program partnership with schools

NPM 13.2 Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives: By 2025, increased preventive dental care services for adolescent 15-17 yrs old by 5% yearly

Strategies:

- Strengthen partnership with Public School System for dental services availability in public school
    - Ensure dental services outreach school schedule is regularly updated and submitted to Public School System
    - At the beginning of the school year, Ministry of Health and Human Services Public Health programs meet with the PTAs for awareness of PH services offered in the school.
- Conduct community/school awareness of proper oral hygiene.
    - Develop IEC Oral Health materials that are translated into Marshallese and other common languages in RMI
    - Conduct community and school oral health awareness activities
    - Engage different platforms to disseminate IEC materials like social media posting, newspaper advertisement, radio spots and school bulletin boards.

RMI will continue the activities in 2022. Due to COVID-19 pandemic poreparedness and response, activities were deferred.

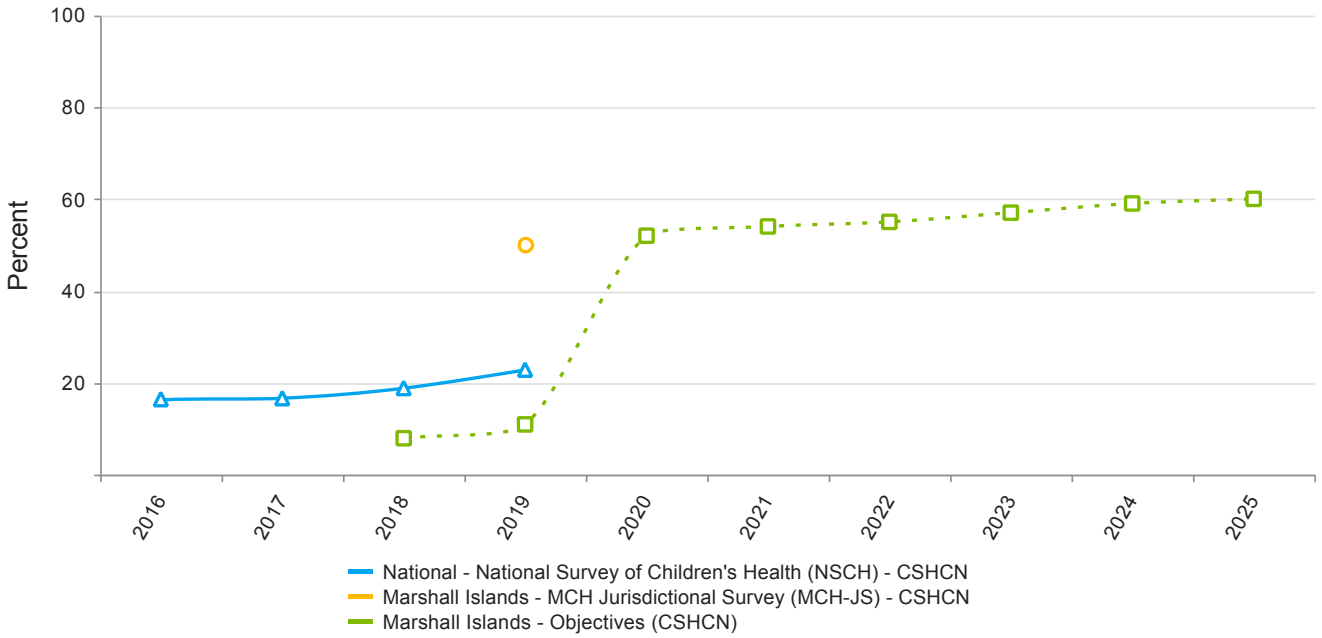
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	MCH-JS-2019	0 %	NPM 12
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 12

National Performance Measures

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN		
	2019	**2020**
Annual Objective	11	52
Annual Indicator	50.0	50.0
Numerator	176	176
Denominator	351	351
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			8	11	52
Annual Indicator	0.1	0	0		
Numerator	10	0	0		
Denominator	7,978	8,045	8,119		
Data Source	MCH Program	MCH Program	MCH Program		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	54.0	55.0	57.0	59.0	60.0	60.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of youths with Special Health Care Need (CSHCN) enrolled in the non-medical related programs to receive services.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2.0	5.0	7.0	9.0	12.0	14.0

State Performance Measures

SPM 5 - Increase percentage of fully immunized children ages 19 to 35 months

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		48	50	63	65
Annual Indicator	46.1	46.8	61.3	64.1	58.6
Numerator	868	795	995	1,014	954
Denominator	1,881	1,697	1,624	1,583	1,629
Data Source	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	65.0	67.0	69.0	70.0	72.0	72.0

State Action Plan Table

State Action Plan Table (Marshall Islands) - Children with Special Health Care Needs - Entry 1

Priority Need

Develop and implement clinical management, guidelines and registry for Children with Special Health Care Needs.

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Objectives

By 2025, MCH Program with partnership created and implemented the non-medical related programs for CSHCN.

Strategies

Develop transition plan in partnership with government agencies, NGOs and chamber of commerce

Develop and implement clinical management guidelines for CSHCN referrals

ESMs	Status
ESM 12.1 - Percent of youths with Special Health Care Need (CSHCN) enrolled in the non-medical related programs to receive services.	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Children with Special Health Care Needs - Annual Report

Children with Special Health Care Needs Annual Report

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

	2016	2017	2018	2019*	2020
NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care	0	0	0	50	

*MCH JS

2019: Result for the MCH JS is linked in the MCH BG application.

2018: This NPM will be part of the Jurisdiction Survey to be able to get better information.

2017: this NPM will be part of the Jurisdiction Survey to be able to get better information. For 2017, no survey was done to capture this data. In 2018, we will work with Children's clinic to endorse >14 years old that needs assistance to transition to adult health care.

2016: RMI is only reporting CSHCN data - Only 10 out of the 300 identified CSHCN moved from pediatric to adult care. For RMI, Child health care services are provided from 0-14 years old. For 15 and up, the patients are referred to adult care which are in the main outpatient and public health clinics. For this measure, we have to establish a method to measure using survey if the patients know the transition in their health care.

Activities implemented:
Program collaborated with UH on referral on patients to Shriners' annual visit. Three children with special needs with orthopedic problems were followed up and given appointment to see Doctors from Shriners. It was a good result, all 3 children were referred for rehabilitation and wheelchairs were provided for free for easy mobilization. After the meeting it was agreed that programs will be sharing information on database to make sure all clients are registered. Data from EHDI has been shared but not PSS.

Program was also able to meet with the EHDI program and consultants and family representative to discuss on issues facing the children with special health care needs in the schools.

-Staff implementing early newborn hearing screening were able to attend the annual conference which is necessary to better serve the population.

Accomplishment:
-Collaboration with EHDI and Public School System
-Program has partnered with Disability unit at the Ministry of Culture and Internal Affairs (MOCIA) for patient referral especially from the outer islands. With the recent development, MCH Program collaborated with MOCIA and other partners for the development and implementation of Disability ID which will give monthly discounts to the disabled children. An initiative that will greatly benefit the CSHCN.

Challenges:
-Need additional staff for the program to implement activities
- Weak case finding activities mainly in the outer islands.

Plan:
Data can be extracted from the MCH jurisdictional survey
The development of the CSHCN Registry and referral system in Marshall Health Information System.

MCH Program continues to provide services to CSHCN patients.
Through MCH Block Grant, we fund the patients for their travel and 2 weeks stipend for their medical referral to Shriners' Hospital. After 2 weeks, Medical Referral office will assume the stipend of the patients and escort.

There were 2 children with special health care needs referred to Shriners' Hospital. It was a challenge to refer the CSHCN because of the COVID-19 pandemic and RMI's closure of borders.

Program continue to work with Disability Group in conducting awareness activities, scheduling and referral of CSHCN.

With the COVID-19 Pandemic, MCH program developed a plan to ensure that the CSHCN's health care needs will be addressed. Teleheatlh program is in development which will be used as another platform to reach CSHCN population.

Children with Special Health Care needs Annual Plan

Population Domain: Children with Special Health Care Needs
Priority Need: Develop and implement clinical management, guidelines and registry for Children with Special Health Care Needs.

NPM 12 Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health car

Objective: By 2025, MCH Program with partnership created and implemented the non-medical related programs for CSHCN.

Strategies:

- Develop transition plan in partnership with government agencies, NGOs and chamber of commerce

The MCH Blok Grant with support and endorsement from Ministry of Health and Human Services (MOHHS) leadership to create a task force that will manage the development of the transition plan. Regular meetings with the task force to develop the plan. MCH Block grant program to support the meetings for venue and supplies. We will create listing of services and benefits available for the CSHCN population. Draft Transition Plan will be presented to MOHHS Leadership and stakeholders.

- Develop and implement clinical management guidelines for CSHCN referrals

MCH Block Grant will organize a workshop with clinical staff and partners to develop the clinical management guidelines for CSHCN referrals by 1st quarter of 2022. Draft guidelines will be presented to the MOHHS leadership for review and endorsement before the end of 2022.

Cross-Cutting/Systems Building

State Action Plan Table

State Action Plan Table (Marshall Islands) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Child Oral Health Program partnership with schools
Objectives
By 2025, increased preventive dental care services by 5% yearly
By 2025, Oral Health services visited at least 90% of the elementary and high schools in RMI
Strategies
Oral health services will conduct outreach visits to the schools yearly
Increase campaign and awareness on oral health hygiene and available services

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

MCH Needs Assessment Stakeholder Public Input Survey

During the development of the 2021 MCH Services Title V Block Grant, RMI distributed a public input survey to collect on-going input on services, emerging issues, needs, and concerns from informed consumers and partners in the RMI. The purpose of the survey was to collect information and perspectives on the needs and to also involve partners across the RMI who could assist in assessing needs based on existing services and resources. Results are presented by MCH Domains.

Figure 8. Women/Maternal Health Issues Ranking, RMI, 2020

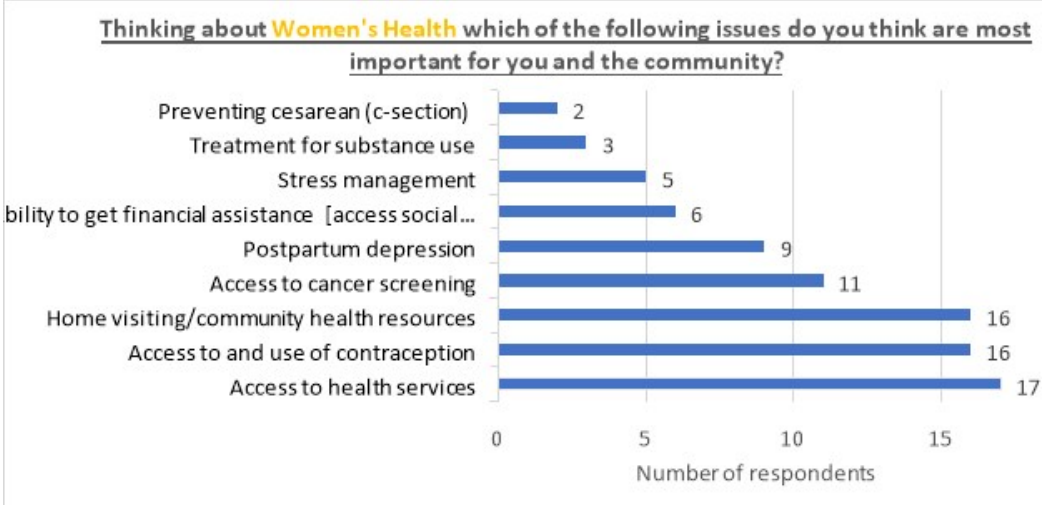


Figure 9. Infant Health Issues Ranking, RMI, 2020

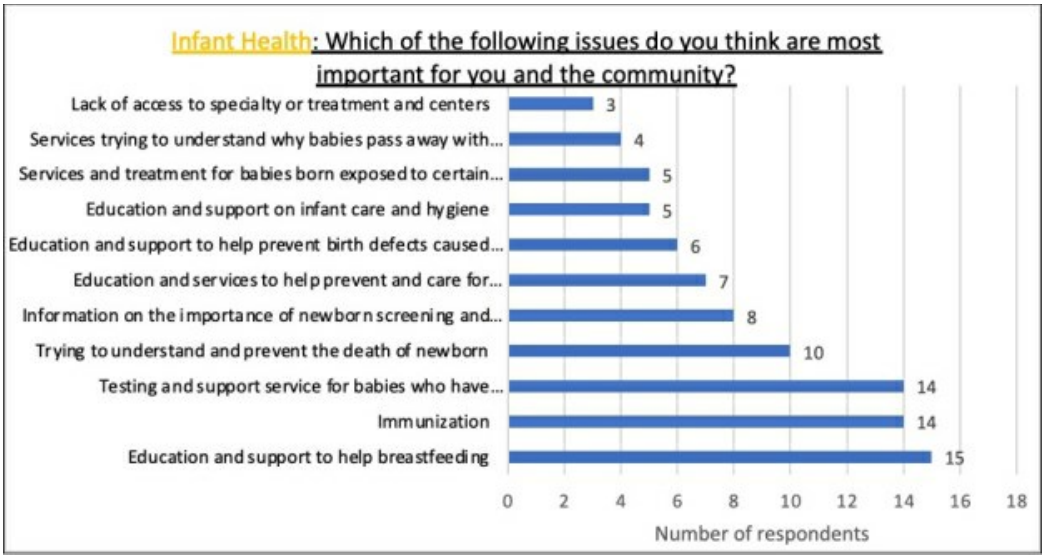


Figure 10. Child Health Issues Ranking, RMI, 2020

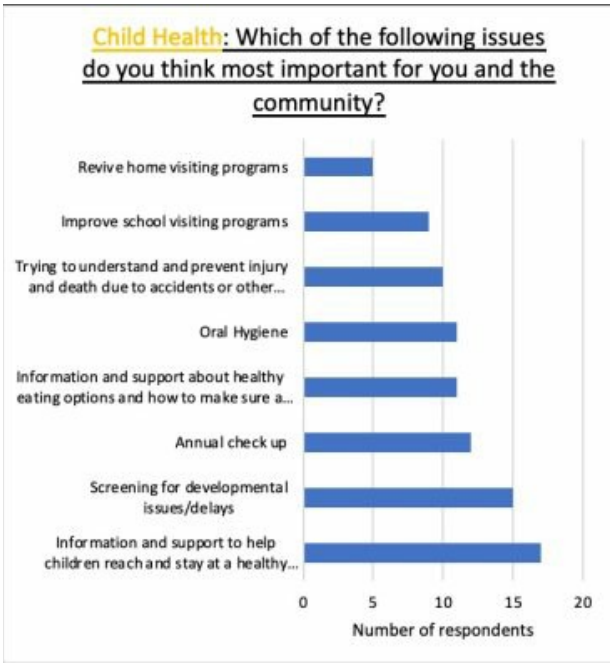


Figure 11. Adolescent Health Issues Ranking, RMI,2020

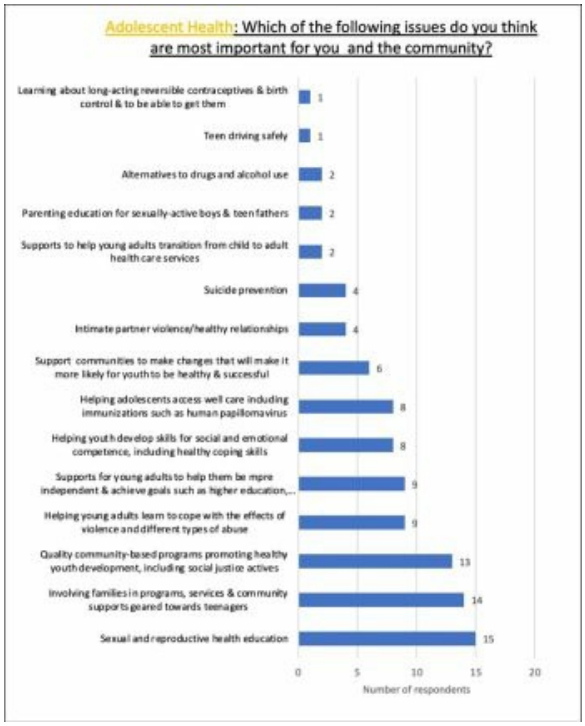


Figure 12. Children with Special Health Care Needs Health Issues Ranking, RMI, 2020

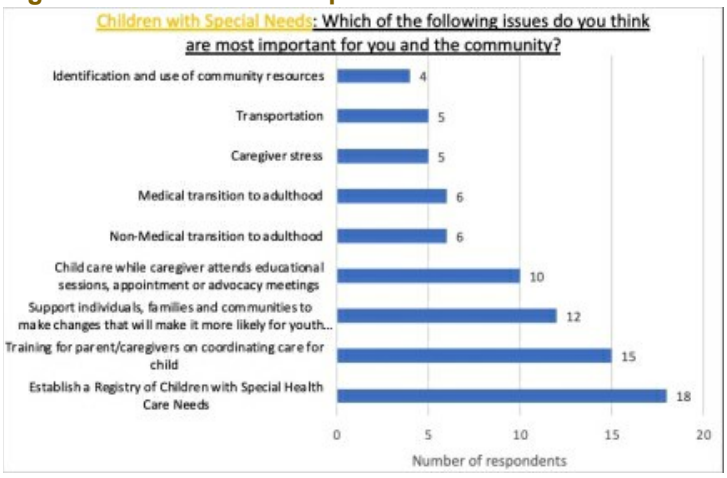


Figure 13. Most frequent Parent Education Strategies, RMI, 2020

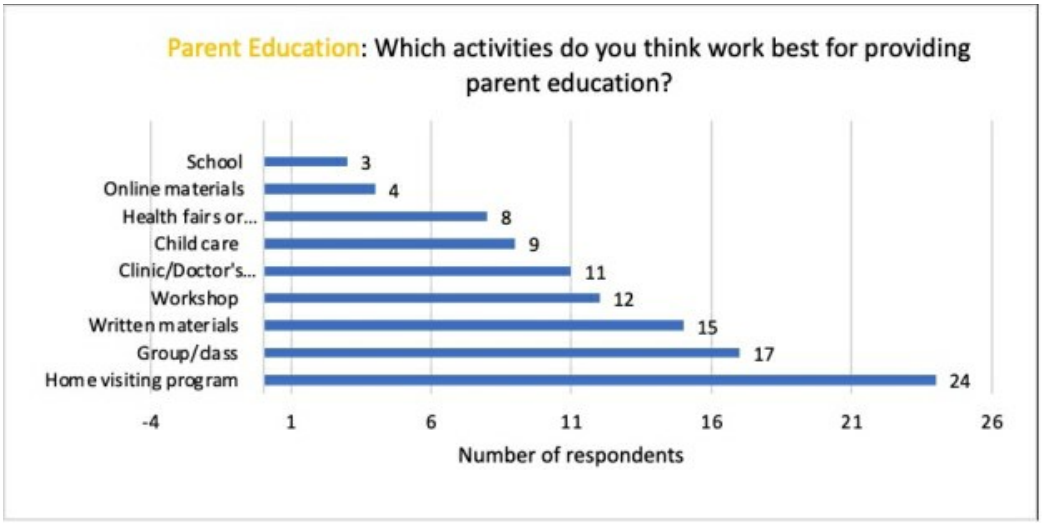


Figure 14. Cross-cutting/Life Span Health Issues, RMI, 2020

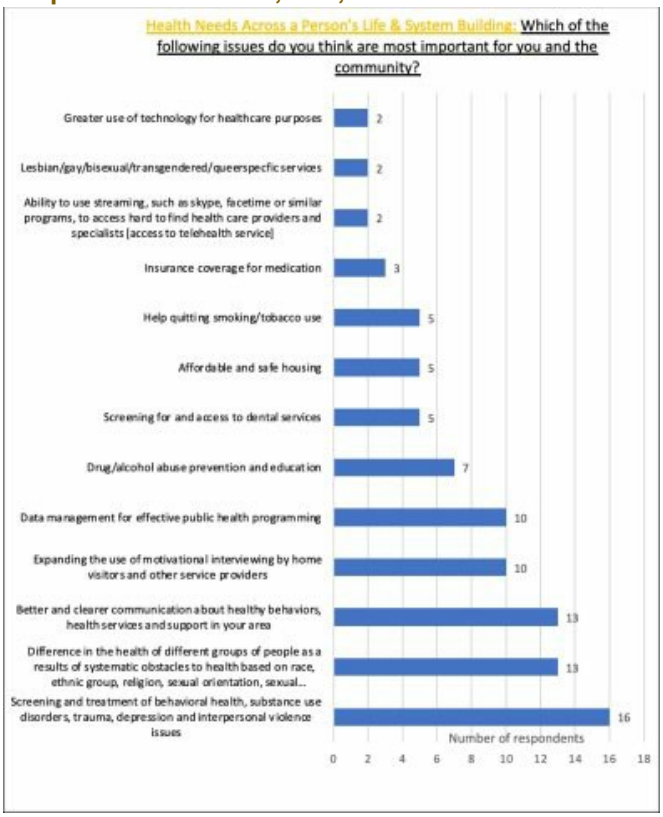
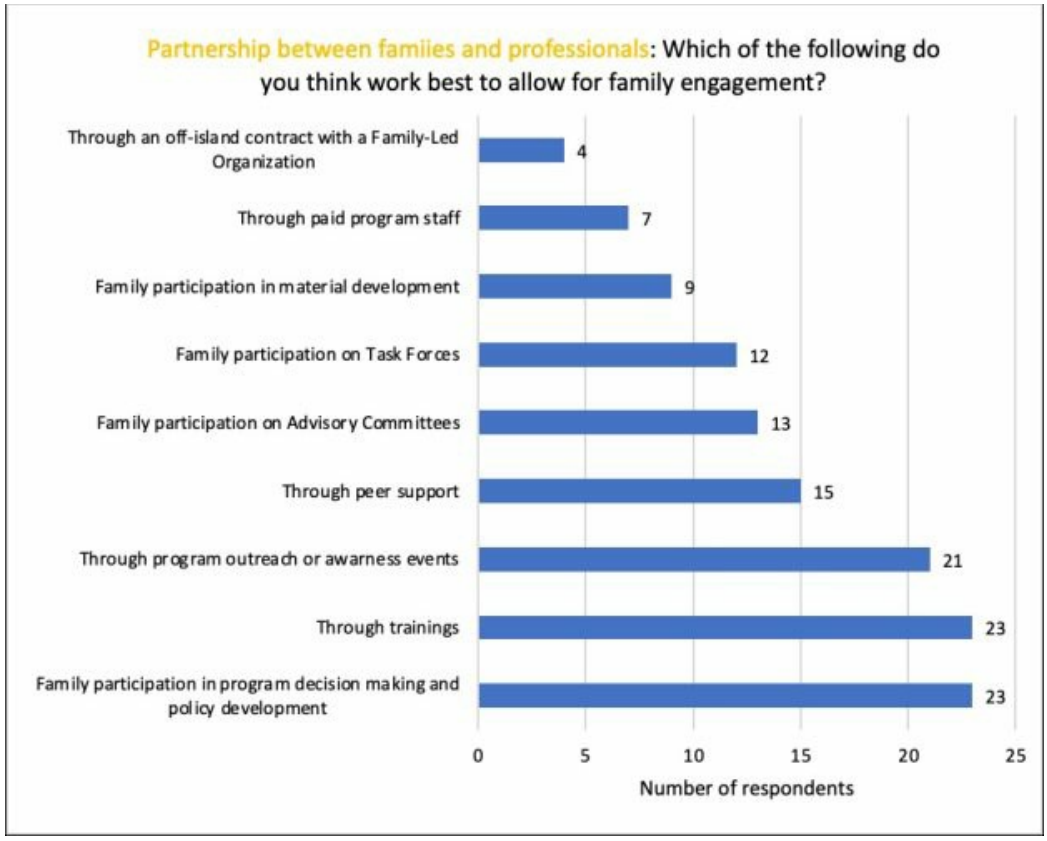


Figure 15. Strategies for Family Engagement, RMI, 2020


Partnership between families and professionals: Which of the following do you think work best to allow for family engagement?
Through an off-island contract with a Family-Led Organization
4
Through paid program staff
7
Family participation in material development
9
Family participation on Task Forces
12
Family participation on Advisory Committees
13
Through peer support
15
Through program outreach or awarness events
21
Through trainings
23
Family participation in program decision making and policy development
23
0
5
10
15
20
25
Number of respondents

III.G. Technical Assistance

The MCH Program needs technical assistance on the following areas:

1 FIMR:

The program needs assistance on developing a team to focus on this area. We currently have a perinatal committee which consists of program staff, maternity and labor staff, OBGYNs. This committee conducts biannual meetings where charts are reviewed, and discussions made on how to improve services and quality patient care. No meetings in 2020 due to the pandemic.

2. The program needs assistance on BSS for the Oral Health Program, TA submitted, pending due to the pandemic.

With the TA, program will be able to acquire the necessary knowledge and skills to conduct BSS in RMI. The program will be able to obtain the vital data needed thru BSS and use data as needed to formulate feasible plans to address areas

3. Technical Assistance on the Financial part of the Application. This part was addressed during MCHB site visit but MCH Program Director wants to be more detailed. TA completed in April 2021.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Medicaid.pdf

V. Supporting Documents

No Supporting documents were provided by the state.

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Organization Chart 2020.pdf

VII. Appendix

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: Marshall Islands

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 229,808	
A. Preventive and Primary Care for Children	$ 68,943	(30%)
B. Children with Special Health Care Needs	$ 68,943	(30%)
C. Title V Administrative Costs	$ 22,980	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 160,866	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 2,646,295	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 2,646,295	
A. Your State's FY 1989 Maintenance of Effort Amount $ 175,745		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 2,876,103	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 200,000	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 3,076,103	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 150,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 50,000

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 226,000		$ 223,723	
A. Preventive and Primary Care for Children	$ 67,800	(30%)	$ 65,548	(29.2%)
B. Children with Special Health Care Needs	$ 67,800	(30%)	$ 67,152	(30%)
C. Title V Administrative Costs	$ 22,600	(10%)	$ 22,300	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 158,200		$ 155,000	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 200,000		$ 2,646,295	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 200,000		$ 2,646,295	
A. Your State's FY 1989 Maintenance of Effort Amount $ 175,745				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 426,000		$ 2,870,018	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 150,000		$ 184,125	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 576,000		$ 3,054,143	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 150,000	$ 135,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)		$ 49,125

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Annual report expended is less than 30% due to back order of supplies on Purchase Requisitons and RMI travel restriction due to COVID 19	
2.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: State MCH funds include salaries for physicians and nurses providing services for the MCH population	

Data Alerts:

- The value in Line 1A, Preventive and Primary Care for Children, Annual Report Expended is less than 30% of the Federal Allocation, Annual Report Expended. A field-level note indicating the reason for the discrepancy was provided.

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Marshall Islands

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 38,000	$ 36,402
2. Infants < 1 year	$ 30,942	$ 30,943
3. Children 1 through 21 Years	$ 68,943	$ 65,548
4. CSHCN	$ 68,943	$ 67,152
5. All Others	$ 0	$ 1,378
Federal Total of Individuals Served	$ 206,828	$ 201,423

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 527,620	$ 527,620
2. Infants < 1 year	$ 175,660	$ 175,660
3. Children 1 through 21 Years	$ 170,735	$ 170,735
4. CSHCN	$ 183,000	$ 183,000
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 1,057,015	$ 1,057,015
Federal State MCH Block Grant Partnership Total	$ 1,263,843	$ 1,258,438

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Marshall Islands

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 61,114	$ 61,114
3. Public Health Services and Systems	$ 168,694	$ 162,609
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 229,808	$ 223,723

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 43,000	$ 43,000
3. Public Health Services and Systems	$ 1,014,015	$ 1,014,015
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 1,057,015	$ 1,057,015

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Marshall Islands

Total Births by Occurrence: 1,028 **Data Source Year: 2020**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	931 (90.6%)	13	13	13 (100.0%)

Program Name(s)
Hearing Loss

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Early Intervention is provided to all babies who have been identified with a hearing loss/deafness. These families get home visits once a week and join a playgoup also once a week. Families on Ebeye only receive weekly home visits.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2020**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: Live births in RMI: 1028 Majuro: 681; Ebeye: 266; Outer Islands: 81	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2020**
	Column Name:	**Data Source Year Notes**
	Field Note: Live births in RMI	
3.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: Majuro: 670 (11 of the 670 were infant deathbed was tested for Newborn hearing Screening); Ebeye: 261 (3 of the 261 were infant deathbed was tested for Newborn hearing Screening)	
4.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: Majuro : 9 and Ebeye: 4; Total of 13. There 13 are managed by Early intervention program. Early Intervention is provided to all babies who have been identified with a hearing loss/deafness. These families get home visits once a week and join a playgoup also once a week. Families on Ebeye only receive weekly home visits.	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Marshall Islands

Annual Report Year 2020

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,631	0.0	0.0	100.0	0.0	0.0
2. Infants < 1 Year of Age	1,028	0.0	0.0	100.0	0.0	0.0
3. Children 1 through 21 Years of Age	3,588	0.0	0.0	100.0	0.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	89	0.0	0.0	100.0	0.0	0.0
4. Others	2,024	0.0	0.0	100.0	0.0	0.0
Total	8,271					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	1,793	No	1,631	100.0	1,631	1,631
2. Infants < 1 Year of Age	1,753	No	1,028	100.0	1,028	1,028
3. Children 1 through 21 Years of Age	34,454	No	27,407	22.0	6,030	3,588
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,810	Yes	1,810	10.0	181	89
4. Others	40,425	No	26,190	30.0	7,857	2,024

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**
	Field Note: Pregnant women that visited Prenatal Clinic in Majuro, Ebeye and Outer Islands.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: Infants served in MCH clinics. Supported by the program in terms of staff, medical supplies and training.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Total 1-21 years old served include patients from Children's Clinics, Prenatal Clinics, Women's Health, and Dental Clinics.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Children with Special Health Care Needs that were able to come to the services.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Number reflects the patients that come to the Women's Clinic with services but not limited to cervical cancer screening, OB-GYNE cases, women missions wherein MCH Block Grant supports the staff, clinic supplies, office supplies, laboratory testings and training (on-island and off-island).	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**
	Field Note: Denominator is based on women with live births in RMI. Numerator is based on number of women with live births in RMI.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**
	Field Note: Denominator is based on live births in RMI. Numerator is based on live births in RMI.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Denominator is based on RMI Projected Population of 2020. Total served (6,030) is based on the 1-21 yrs old that were given services in the Ministry of Health and Human Services.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: MCH Block grant program coordinates with Special Education which includes policies, initiatives and workforce capacity.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Denominator is based on RMI Projected Population of 2020. Total served (7857) is based on the 22 yrs old and above that were given services in the Ministry of Health and Human Services.	

Data Alerts:

1.	Pregnant Women, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
2.	Infants Less Than One Year, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Marshall Islands

Annual Report Year 2020

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	1,028	0	0	0	0	7	1,006	15	0
Title V Served	1,028	0	0	0	0	7	1,006	15	0
Eligible for Title XIX	0	0	0	0	0	0	0	0	0
2. Total Infants in State	1,582	0	0	0	0	0	1,582	0	0
Title V Served	1,028	0	0	0	0	7	1,006	15	0
Eligible for Title XIX	0	0	0	0	0	0	0	0	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Data source : Vital Records Information System for FY2020 deliveries	
2.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Data source: RMI Projected population for 2021. Information on the race and ethnicity is not available.	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Marshall Islands

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(692) 625-7007 x2275	(692) 625-7007 x2275
2. State MCH Toll-Free "Hotline" Name	Maternal and Child Health Program	Ministry of Health and Human Services
3. Name of Contact Person for State MCH "Hotline"	Caroline Johnny Jibas	Caroline Johnny- Jibas
4. Contact Person's Telephone Number	(692) 625-7007 x2275	(692) 625-7007 x2275
5. Number of Calls Received on the State MCH "Hotline"		62

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names	Ministry of Health and Human Services	Ministry of Health and Human Services
2. Number of Calls on Other Toll-Free "Hotlines"		20
3. State Title V Program Website Address	in progress	in progress
4. Number of Hits to the State Title V Program Website		0
5. State Title V Social Media Websites	https://www.facebook.com/rmimoh/	https://www.facbeook.com/rmimoh/
6. Number of Hits to the State Title V Program Social Media Websites		4,000

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Marshall Islands

1. Title V Maternal and Child Health (MCH) Director	
Name	Caroline Johnny Jibas
Title	MCH Director
Address 1	P.O. BOX 16 Delap
Address 2	
City/State/Zip	Majuro / MH / 96960
Telephone	(692) 625-7007
Extension	2275
Email	cjibas@rmihealth.org

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Caroline Johnny Jibas
Title	MCH Director
Address 1	PO. BOX 16 Delap
Address 2	
City/State/Zip	Majuro / MH / 96960
Telephone	(692) 625-7007
Extension	2275
Email	cjibas@rmihealth.org

3. State Family or Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Marshall Islands

Application Year 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Access to coordinated, comprehensive care and services for Women before, during and after pregnancy	Revised
2.	Cancer screening and services for Women's Health	Continued
3.	Infants breastfed exclusively through six months	Continued
4.	Parent-completed developmental screening tools	Continued
5.	Reduce infant mortality rate	New
6.	Child Oral Health Program partnership with schools	Continued
7.	Teen reproductive health and pregnancy prevention.	Revised
8.	Develop and implement clinical management, guidelines and registry for Children with Special Health Care Needs.	Continued
9.	Improve adolescent health through promotion of adolescent well-being.	Revised

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Access to coordinated, comprehensive care and services for Women before, during and after pregnancy	Revised
2.	Cancer screening and services for Women's Health	Continued
3.	Infants breastfed exclusively through six months	Continued
4.	Parent-completed developmental screening tools	Continued
5.	Reduce infant mortality rate	New
6.	Child Oral Health Program partnership with schools	Continued
7.	Teen reproductive health and pregnancy prevention.	Revised
8.	Develop and implement clinical management, guidelines and registry for Children with Special Health Care Needs.	Continued
9.	Improve adolescent health through promotion of adolescent well-being.	Revised

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Marshall Islands

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	34.9
Numerator	359
Denominator	1,028
Data Source	MCH Program
Data Source Year	2020

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	19.5
Numerator	2
Denominator	1,028
Data Source	Vital Records Information System
Data Source Year	2020

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	194.6
Numerator	2
Denominator	1,028
Data Source	Vital Statistics Information System
Data Source Year	2020

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	9.8 %	1.8 %	2,389	24,274

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	13.4
Numerator	138
Denominator	1,028
Data Source	Vital Statistics Information System
Data Source Year	2020

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	21.5 %	4.1 %	5,225	24,274

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	8.2
Numerator	84
Denominator	1,028
Data Source	Vital Statistics Information System
Data Source Year	2020

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	22.4
Numerator	230
Denominator	1,028
Data Source	Vital Statistics Information System
Data Source Year	2020

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Federally available Data (FAD) for this measure is not available/reportable.

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	19.5
Numerator	20
Denominator	1,028
Data Source	Vital Registration Information System
Data Source Year	2020

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	26.4		36	
2018	27.4		38	
2017	28.1		40	
2016	28.8		41	
2015	29.5		43	
2014	30.1		45	
2013	30.6		47	
2012	31.1		49	
2011	31.5		51	
2010	31.7		53	
2009	31.8		54	

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	20.4
Numerator	21
Denominator	1,028
Data Source	Vital Registration Information System
Data Source Year	2020

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	15.3		21	
2018	15.5		21	
2017	16.0		22	
2016	16.4		23	
2015	16.9		25	
2014	17.2		26	
2013	17.5		27	
2012	17.7		28	
2011	17.8		29	
2010	18.0		30	
2009	18.0		31	

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	9.7
Numerator	10
Denominator	1,028
Data Source	Vital Registration Information System
Data Source Year	2020

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	10.7
Numerator	11
Denominator	1,028
Data Source	Vital Registration Information System
Data Source Year	2020

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	291.8
Numerator	3
Denominator	1,028
Data Source	Vital Records Information System
Data Source Year	2020

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	97.3
Numerator	1
Denominator	1,028
Data Source	Vital Registration Information System
Data Source Year	2020

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	1.6
Numerator	16
Denominator	1,028
Data Source	MCH Program
Data Source Year	2020

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	0.0
Numerator	0
Denominator	950
Data Source	Vital Records Information System and MHIS
Data Source Year	2020

NOM 11 - Notes:

None

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 11. Please review your data to ensure this is correct.

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	23.8 %	4.2 %	5,528	23,195

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	65.8
Numerator	9
Denominator	13,679
Data Source	Vital Records Information System
Data Source Year	2020

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	86.6
Numerator	10
Denominator	11,542
Data Source	Vital Records Information System
Data Source Year	2020

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	0.0
Numerator	0
Denominator	4,857
Data Source	Vital Records Information System
Data Source Year	2020

NOM 16.2 - Notes:

None

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 16.2. Please review your data to ensure this is correct.

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	41.2
Numerator	2
Denominator	4,857
Data Source	Vital Records Information System
Data Source Year	2020

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	5.0 %	1.3 %	1,203	24,274

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	0.4
Numerator	89
Denominator	24,195
Data Source	MCH Program
Data Source Year	2020

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	0 %	0	0	1,203

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	1.6 %	0.7 %	308	19,810

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	2.0 %	0.8 %	393	19,810

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	13.4 % ϟ	6.9 % ϟ	124 ϟ	923 ϟ

Legends:

ϟ Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	57.2 %	4.6 %	13,888	24,274

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2007	24.9 %	1.2 %	342	1,374

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS) - Age 10-17

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	18.2 %	4.5 %	1,728	9,514

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	86.5 %	3.3 %	20,995	24,274

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Federally available Data (FAD) for this measure is not available/reportable.

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	28.5
Numerator	6,641
Denominator	23,339
Data Source	Immunization Program, WebIZ
Data Source Year	2020

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	40.3
Numerator	2,202
Denominator	5,464
Data Source	Immunization Program, WebIZ
Data Source Year	2020

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	18.6
Numerator	1,015
Denominator	5,464
Data Source	Immunization Program, WebIZ
Data Source Year	2020

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	15.3
Numerator	836
Denominator	5,464
Data Source	Immunization Program, WebIZ
Data Source Year	2020

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	65.7
Numerator	156
Denominator	2,375
Data Source	Vital Records Information System
Data Source Year	2020

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	1.6
Numerator	16
Denominator	1,028
Data Source	MCH Program
Data Source Year	2021

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	10.3 %	2.6 %	2,502	24,274

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Marshall Islands

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective		48
Annual Indicator	48.3	48.3
Numerator	8,951	8,951
Denominator	18,513	18,513
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	20	24	37	39	48
Annual Indicator	21.7	35.4	37.7		
Numerator	2,150	3,605	3,733		
Denominator	9,891	10,197	9,896		
Data Source	MCH Program	MCH Program	MCH Program		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	50.0	52.0	54.0	56.0	58.0	58.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Preventive medical visit for women includes papsmear/VIA screening, breast cancer screening, family planning counselling, STI/HIV Screening, TB Screening, Leprosy Screening and Immunization service (Hep B, MCV4, Flu - for immunocompromise) in Majuro Hospital and Ebeye Hospital.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Preventive medical visit for women includes papsmear/VIA screening, breast cancer screening, family planning counselling, STI/HIV Screening, TB Screening, Leprosy Screening and Immunization service (Hep B, MCV4, Flu - for immunocompromise) in Majuro Hospital, Ebeye Hospital and Outer Islands (that reported on time)	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Preventive medical visit for women includes papsmear/VIA screening, breast cancer screening, family planning counselling, STI/HIV Screening, TB Screening, Leprosy Screening and Immunization service (Hep B, MCV4, Flu - for immunocompromise) in Majuro Hospital, Ebeye Hospital and Outer Islands (that reported on time)	

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator	0	0
Denominator	2	8
Data Source	MOHHS	Vital Records Information System
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	1.0	1.0	2.0	2.0	2.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: This is a new PM. During the Needs Assessment, the stakeholders identified that our hospital need to improve its birthing and neonatal facilities.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Our hospitals is not a Level III+ Neonatal Intensive Care Unit (NICU). But we have a NICU for both Majuro and Ebeye Hospitals.	

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	100	56
Annual Indicator	55.8	55.8
Numerator	5,143	5,143
Denominator	9,218	9,218
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	90	100	100	100	56
Annual Indicator	100	100	100		
Numerator	1,089	989	989		
Denominator	1,089	989	989		
Data Source	MCH Program	MCH Program	RMI ICHNS		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	58.0	60.0	62.0	64.0	65.0	66.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Once the mothers give birth, the newborns are immediately breastfed. RMI practice First Embrace. First embrace is life saving skin to skin contact immediately after birth between the baby and the mother.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Once the mothers give birth, the newborns are immediately breastfed. RMI practice First Embrace. First embrace is life saving skin to skin contact immediately after birth between the baby and the mother.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Once the mothers give birth, the newborns are immediately breastfed. RMI practice First Embrace. First embrace is life saving skin to skin contact immediately after birth between the baby and the mother.	

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	50	53	42	44	44
Annual Indicator	50.3	40.5	42.3	42.3	42.3
Numerator	548	401	373	373	373
Denominator	1,089	989	881	881	881
Data Source	MCH Program	MCH Program	RMI ICHNS	RMI ICHNS	RMI ICHNS
Data Source Year	2016	2017	2018	2018	2018
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	46.0	48.0	50.0	52.0	54.0	55.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: In the Perinatal/Infant Health, we will present the result of the latest Integrated Child and Nutrition Survey 2017.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data presented is from RMI Integrated Child Health and Nutrition Survey. There are 881 children under 5 yrs old from Majuro, Ebeye and Outer Islands.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data presented is from RMI Integrated Child Health and Nutrition Survey. There are 881 children under 5 yrs old from Majuro, Ebeye and Outer Islands. This is one of RMI State Priority. MCH Program with collaboration with other programs developed a milestone passport/passbook which will enable us to measure this NPM. There will be activities laid out to improve this indicator.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data presented is from RMI Integrated Child Health and Nutrition Survey.	

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	46	48
Annual Indicator	1.5	1.5
Numerator	53	53
Denominator	3,619	3,619
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			44	46	48
Annual Indicator	43.9	42.8	30.8		
Numerator	1,668	532	500		
Denominator	3,801	1,243	1,624		
Data Source	MCH Program	MCH Program	MCH Program		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Provisional	Provisional		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	50.0	52.0	55.0	57.0	59.0	60.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Currently, the developmental screening tool is completed by the nurses and the parent/s. It is easier for the health care professional and the parents to have it this way so that the health care professional explains the screening tool. In this reporting period, MCH program with PIHOA-Zika consultant updated the developmental tool. We are in the process of update our data system to accommodate the revision of the developmental tool.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data reported is for Majuro Only. Ebeye and Outer Islands needs more training. It was a challenge to collect and report this data because system was not update. In 2018, this measure will be collected and reported from the main hospital information system called mHIS.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data reported is for Majuro Only. Ebeye and Outer Islands needs more training. It was a challenge to collect and report this data because the information system needs to be updated. In 2018, the mHIS (Marshall Hospital Information System) roll out on outpatient first and plan for MCH clinic will be in 2019-2020.	

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	62	64
Annual Indicator	45.9	45.9
Numerator	2,966	2,966
Denominator	6,465	6,465
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			60	62	64
Annual Indicator	17.2	61.4			
Numerator	1,375	4,943			
Denominator	7,978	8,045			
Data Source	Public Health Programs	Public Health Programs			
Data Source Year	2016	2017			
Provisional or Final ?	Final	Final	Final		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	66.0	66.0	66.0	68.0	68.0	68.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Preventive medical visit services include Eye check up, Stool and urine analysis, Immunization, TB Screening, Leprosy Screening and STI/HIV Screening. Due to limited and availability of complete services in the Outer Islands, preventive medical visit is only given in Majuro Hospital and Ebeye Hospital. Medical clearance is required for high school and college entry, food handlers, work clearance and immigration.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Preventive visits: 12-17 yrs old that visits Immunization program for vaccination (Tdap, MCV, HPV), HIV/STI screening test, Family Planning services, and prenatal services for teen pregnancy.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Preventive visits: 12-17 yrs old that visits Immunization program for vaccination (Tdap, MCV, HPV), HIV/STI screening test, Family Planning services, and prenatal services for teen pregnancy. In this reporting period, we included the 12-17 yrs old with TB/Leprosy Mass Screening in Majuro.	

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN		
	2019	**2020**
Annual Objective	11	52
Annual Indicator	50.0	50.0
Numerator	176	176
Denominator	351	351
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			8	11	52
Annual Indicator	0.1	0	0		
Numerator	10	0	0		
Denominator	7,978	8,045	8,119		
Data Source	MCH Program	MCH Program	MCH Program		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	54.0	55.0	57.0	59.0	60.0	60.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: RMI is only reporting CSHCN data - Only 10 out of the 300 identified CSHCN moved from pediatric to adult care. For RMI, Child health care services are provided from 0-14 years old. For 15 and up, the patients are referred to adult care which are in the main outpatient and public health clinics. For this measure, we have to establish a method to measure using survey if the patients know the transition in their health care.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: This NPM will be part of the Jurisdiction Survey to be able to get better information. For 2017, no survey was done to capture this data. In 2018, we will work with Children's clinic to endorse >14 years old that needs assistance to transition to adult health care.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: This NPM will be part of the Jurisdiction Survey to be able to get better information.	

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective		
Annual Indicator	25.2	25.2
Numerator	5,835	5,835
Denominator	23,195	23,195
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	27.0	29.0	31.0	33.0	35.0	35.0

Field Level Notes for Form 10 NPMs:

None

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Adolescent Health

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	12.0	14.0	16.0	18.0	18.0

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Marshall Islands

2016-2020: NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CHILD		
	2019	**2020**
Annual Objective	106	106
Annual Indicator	10.9	10.9
Numerator	1,612	1,612
Denominator	14,760	14,760
Data Source	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	625	112	110	106	106
Annual Indicator	114.4	108.7	34.6		
Numerator	32	16	5		
Denominator	27,965	14,716	14,457		
Data Source	Hospital Database	Hospital Database	Hospital Database		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Diagnosis for hospitalization are burn, injury, suicide, MVA, and environmental accident.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Cause of hospitalization: Burn, Fall,Drowning, Moving Vehicle Accident, hot liquid, injury.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Diagnosis for hospitalization are head injury, burn and MVA	

Form 10
State Performance Measures (SPMs)

State: Marshall Islands

SPM 1 - Percent of Women ages 25-49 yrs old screened for cervical cancer.

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective	20	11	13	13
Annual Indicator	10.3	10.9	13.4	10.8
Numerator	828	856	892	917
Denominator	8,009	7,849	6,644	8,529
Data Source	MCH Program	MCH Program	MCH Progam	MCH Program
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	12.0	14.0	16.0	18.0	20.0	22.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Population is based on the midyear population for 2020.

SPM 2 - Percent of women ages 15-44 years old that use family planning services

Measure Status:	Active

State Provided Data

	2017	2018	2019	2020
Annual Objective	16	18	20	16
Annual Indicator	15.5	16.8	14.5	11
Numerator	1,825	1,984	1,773	1,353
Denominator	11,773	11,790	12,255	12,271
Data Source	Family Planning Program	Family Planning Program	Family Planning Program	Family Planning Program
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Provisional

Annual Objectives

	2021	2022	2023	2024	2025	2026
Annual Objective	15.0	16.0	17.0	18.0	19.0	20.0

Field Level Notes for Form 10 SPMs:

1. **Field Name:** **2020**

Column Name: **State Provided Data**

Field Note:
In FY2020, there was delay in visiting the Outer Islands for mobile visits due to the preparedness and response activities on COVID-19 Pandemic. Staff were re-assign to manage the quarantine facilities with other Public Health staff.

We plan to revisit all the active Family Planning Clinic charts to find any missing data entry, recalculating of Jadelle users and women that are in BTL.

SPM 3 - Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			37	33
Annual Indicator			31.1	34.9
Numerator			372	359
Denominator			1,198	1,028
Data Source			MCH Program	MCH Program
Data Source Year			2019	2020
Provisional or Final ?			Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	35.0	37.0	39.0	41.0	43.0	43.0

Field Level Notes for Form 10 SPMs:

None

SPM 4 - Increase use of Family planning services to teenagers ages 13 to 17 years old

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective	10	20	20	13
Annual Indicator	18.6	18.8	11.8	21
Numerator	124	126	79	115
Denominator	6,650	6,686	6,686	5,464
Data Source	Family Planning Program	Family Planning Program	Family Planning Program	Family Planning Program
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	22.0	24.0	26.0	28.0	30.0	30.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data is presented in rate. Rate per 1,000 Teenagers 13-17 yrs old.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data is presented in rate. Rate per 1,000 Teenagers 13-17 yrs old. Number of users: Female: 126,; Male: 0 Population: 13-17 yrs old: Female: 3,224 ; Male: 3,461 Total: 6,686	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data is presented in rate. Rate per 1,000 Teenagers 13-17 yrs old. Number of users: Female: 114,; Male: 1 Population: 13-17 yrs old: Female: 2,646 ; Male: 2,818 Total: 5464 Challenge: Family Planning Staff providing after hrs clinic at the Youth to Youth in Health (YTYIH) reported that Youth age 13-17 yrs old are not coming to the clinic. The previous YTYIH Administration hire young teenagers to bring other teenagers to the clinic. YTYIH lost their funding in 2019 - 2020 which affected the services.	

SPM 5 - Increase percentage of fully immunized children ages 19 to 35 months

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		48	50	63	65
Annual Indicator	46.1	46.8	61.3	64.1	58.6
Numerator	868	795	995	1,014	954
Denominator	1,881	1,697	1,624	1,583	1,629
Data Source	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	65.0	67.0	69.0	70.0	72.0	72.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
In 2016-17, RMI has several outbreaks including mumps, Hepatitis A, and conjunctivitis. Immunization nurses were also assigned to work on the Integrated Children Household Nutrition Survey which affected their work in immunization. Immunization schedule to the Outer Islands was also affected due to some administrative requirements which prolonged the processing of travel documents.

In 2017: Majuro - 40.8%, Ebeye - 89.2% and Outer Islands - 21.8% RMI - 46.8%.

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
In 2017: Majuro - 40.8%, Ebeye - 89.2% and Outer Islands - 21.8% RMI - 46.8%.
In 2018: Majuro - 61.24%, Ebeye - 95.19% and Outer Islands - 25.6% RMI - 61.27%.

In this reporting period, Immunization Program was able to achieve its annual objective. Improved data monitoring and reporting was added in the program's activity in 2018. Monthly reporting of data is included in the program's meeting which strategies for improvement were derived. Although the 90% goal for immunization rate is still far, the program will continue to provide outreach services and extended clinic hours to cater to the population that are unable to come to the clinics.

3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
In 2017: Majuro - 40.8%, Ebeye - 89.2% and Outer Islands - 21.8% RMI - 46.8%.
In 2018: Majuro - 61.24%, Ebeye - 95.19% and Outer Islands - 25.6% RMI - 61.27%.
In 2019: Majuro - 67.3%, Ebeye - 95.5% and Outer Islands - 15.6% RMI - 64.1%.

4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
In 2020: Majuro - 63.9%, Ebeye - 84.9% and Outer Islands - 17.1% RMI - 58.6%.

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 7 - Percent of newborns that received Congenital Hypothyroidism newborn screening

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			10	10
Annual Indicator			0	0
Numerator			0	0
Denominator			980	933
Data Source			MCH Program	MCH Program
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Due to Outbreaks and the COVID-19 Pandemics, we were not able to develop this SPM.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Hospital based births in Majuro and Ebeye.	

2016-2020: SPM 8 - Percent of newborn that received congenital cytomegalovirus (CMV) screening

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			5	7
Annual Indicator			0	0
Numerator			0	0
Denominator			980	933
Data Source			MCH Program	MCH Program
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Due to Outbreaks and the COVID-19 Pandemics, we were not able to develop this SPM. MCH Program will work with EHDI Program to be able to research and plan better on this performance measure.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Denominator:Hospital based births in Majuro and Ebeye.	

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Marshall Islands

ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	15.0	20.0	25.0	30.0	30.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.2 - Number of community health centers that provide cancer screening/referrals for women

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.0	2.0	3.0	3.0	5.0	5.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.3 - Percent of women booked for prenatal visit in first trimester

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	22.0	24.0	26.0	28.0	30.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.4 - Percent of women receiving postpartum follow-up health care services within the first four to six weeks after delivery.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	12.0	14.0	16.0	18.0	20.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
MCH and SSDI program are working on the data collection tool that will gather information in Majuro, Ebeye and Outer Islands.

ESM 3.1 - Number of birthing hospitals re-designated with updated standard operating procedures

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.0	1.0	2.0	2.0	2.0	2.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The team led by Clinical Advisor created sub-committee that will review and update the SOPs with current standards of care for both maternal and infant outcomes. We have created google drive to store the library of SOPs that the program have.

ESM 3.2 - Percent of birthing hospitals who complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 3.3 - Percent of newborn babies issued newborn baby health passbook

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	25.0	30.0	35.0	40.0	40.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Due to preparedness and response to COVID-19 Pandemic, the health passbook (milestone passbook) development and implementation was delayed. Committee meetings were conducted. Drafted Marshallese translation of the passbook was distributed for review. First 50 newborns will be registered to use the Milestone Passbook. the 1st 6 months will be used as a quality improvement activity to ensure that we will be able to address any problems before launching it to the health centers

ESM 4.1 - Percent of women provided with in-person or telephonic breastfeeding consults/support services

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
MCH and SSDI Program will work with MIEPI in designing and implementation of data collection tool on this ESM.

ESM 4.2 - Number of MCH staff and community health workers attended the Certified Lactation Counselor training.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	10.0	15.0	20.0	25.0	30.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
Lactation Specialist will be hired under the ECD Program funding. But due to the RMI closure of borders due to the COVID-19 Pandemic, there is a delay in hiring the specialist.

ESM 6.1 - The number of potential high risk screens referred to early intervention

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

None

ESM 10.1 - Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	12.0	15.0	17.0	20.0	25.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.2 - Percent of public middle and high schools visited to deliver pregnancy & STI prevention program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	10.0	15.0	20.0	25.0	30.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Denominator: 2 Middle Schools; 18 Secondary Schools; 2 of the secondary private schools doesn't allow discussion of STIs and Pregnancy.	
2.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: Denominator: 2 Middle Schools; 18 Secondary Schools; 2 of the secondary private schools doesn't allow discussion of STIs and Pregnancy. MCH Program and STI Program are meeting to create an awareness implementation plan.	

ESM 10.3 - HPV vaccine coverage of girls age 13 years

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective	47	37	39	51
Annual Indicator	34.9	36.4	49	33.3
Numerator	230	245	351	206
Denominator	659	673	717	619
Data Source	WebIZ, Immunization Program	WebIZ, Immunization Program	WebIZ, Immunization Program	WebIZ, Immunization Program
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	35.0	36.0	37.0	38.0	39.0	40.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Majuro - 104, Ebeye - 81; Outer Islands - 38

ESM 12.1 - Percent of youths with Special Health Care Need (CSHCN) enrolled in the non-medical related programs to receive services.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2.0	5.0	7.0	9.0	12.0	14.0

Field Level Notes for Form 10 ESMs:

None

ESM 13.2.1 - Percentage of elementary schools visited by dental program

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		14.3
Numerator		16
Denominator		112
Data Source		Dental Clinics/MCH Program
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	15.0	17.0	19.0	21.0	22.0	24.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Denominator - Elementary Schools: 94 schools; Secondary Schools: 18 schools

ESM 13.2.2 - Number of children ages 1-17 years receiving preventive dental care from a dentist.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		20.9
Numerator		2,691
Denominator		12,889
Data Source		Dental Clinics/MCH Program
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	22.0	24.0	26.0	28.0	30.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.2 - Percentage of pregnant women who had at least 4 prenatal visits

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		90	68	69	70
Annual Indicator	88.3	66.1	66.8	64	44.8
Numerator	233	654	661	627	461
Denominator	264	989	989	980	1,028
Data Source	Vital Statistics Department	MCH Program	MCH Program	MCH Program	MCH Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
2016 calculation didn't reflect the live births of 2016. We will recalculate the annual objectives.

2016-2020: ESM 1.3 - Percent of women ages 18 thru 44 seen at outreach mobile visits

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			5	7
Annual Indicator			14.2	18.1
Numerator			1,458	449
Denominator			10,264	2,476
Data Source			MCH Program	MCH Program
Data Source Year			2019	2020
Provisional or Final ?			Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Due to the Dengue Outbreak that started in June 2019, outreach mobile visit was on hold. Travel to Outer Islands was ban. The government doesn't want to spread the Dengue Fever in the Outer Islands. Travel was open again in December 2019.

2016-2020: ESM 1.4 - Number of pregnant women with dental check up

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			50	53
Annual Indicator			42.9	53.3
Numerator			420	869
Denominator			980	1,631
Data Source			Dental Services	Dental Services
Data Source Year			2019	2020
Provisional or Final ?			Final	Provisional

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 4.2 - Percentage of pregnant women that where given comprehensive breastfeeding counselling during prenatal visit

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	70	10	60	62
Annual Indicator	0	58.4	60.6	77.6
Numerator	0	734	726	1,265
Denominator	1,097	1,257	1,198	1,631
Data Source	MCH Program	MCH Program	MCH Program	MCH Program
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Service of breastfeeding counselling is being done in the prenatal clinics. But to collect and enter it in the system is missing. In the prenatal clinical visit form, breastfeeding counselling is not included. In 2017, we included field on breastfeeding counselling. Changes will reflect in 2018 report as this is included in the Reproductive Health Information System. Revision will be implemented in Majuro, Ebeye and Outer Islands.

2016-2020: ESM 6.2 - Percentage of children diagnosed with ASD and ADHD

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			10	12
Annual Indicator			0	10.5
Numerator			0	2
Denominator			1	19
Data Source			MCH Program	Behavioral Healh Clinic - Majuro
Data Source Year			2019	2020
Provisional or Final ?			Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The MCH Program and Behavioral Health Services are in the planning and preparedness stage on the referral of ASD/ADHD cases. RMI don't have pediatric specialist that will manage the referrals on island. We have 1 Psychiatrist that handles all behavioral health services.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Psychiatrist in Behavioral Health Clinic in Majuro developed a referral system with the Majuro Hospital Pediatricians for evaluation of children with behavioral and emotional disorder. Out of the 19 referred patients, there were 2 that meet the clinical diagnosis for ADHD	

2016-2020: ESM 7.1.1 - Number of community campaign on awareness and promotion of child safety within the community.

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	3	3	1	3
Annual Indicator	0	0	0	33.3
Numerator	0	0	0	1
Denominator	3	3	3	3
Data Source	MCH Program	MCH Program	MCH Program	MCH Program
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: In 2017, we worked on our partnership with different stakeholders. No community awareness done in 2017. Translation of materials in to Marshallese is on-going.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: There was no campaign done in 2018. But there is a big project on Early Childhood development which will launch in 2019.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Due to the Dengue Outbreak in 2019, the campaign was on hold.	

2016-2020: ESM 12.2 - Percent of adolescent that moved to adult health care

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	10	15	20	25
Annual Indicator	10	16.1	17.4	22.4
Numerator	1	10	12	15
Denominator	10	62	69	67
Data Source	MCH Program	MCH Program	MCH Program	MCH Program
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: Marshall Islands

SPM 1 - Percent of Women ages 25-49 yrs old screened for cervical cancer.
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To increase the number of women 25-49 yrs old who have cervical cancer screening. To be able to detect early any anomalies that will lead to cervical cancer.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women, age 25-49 yrs old, who had cervical cancer screening in the calendar year **Denominator:** Number of women, age 25-49 yrs old
Data Sources and Data Issues:	RMI MOH MCH Program - Cervical Cancer Screening Database
Significance:	Cervical Cancer is the leading cause of death for Marshallese women. Cervical cancer is the most common type of cancer for female population. The Ministry of Health and Human Services address the increase of cervical cancer cases by emphasizing on the strength of prevention and early detection.

SPM 2 - Percent of women ages 15-44 years old that use family planning services
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To be able to provide full family planning services to all women 15-44 years old in Majuro, Kwajalein and Outer Islands.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of unduplicated family planning method users **Denominator:** Number of female population in RMI between 15-44 years old
Data Sources and Data Issues:	Family planning program database. Users are those using any of the following: female sterilization, male partner sterilized, oral contraceptive, IUD, hormonal implant, hormonal injections, male or female condoms, fertility awareness method, abstinence
Significance:	Family planning services prevent unplanned pregnancies which are more likely than planned pregnancies to occur in young teens, women > 35 years of age, and to women who have had a previous baby without sufficient time to recover (i.e. <1 year between births). Babies from unplanned pregnancies are more likely to be born into poverty, premature, malnourished, and have developmental disabilities. Good coverage of women with family planning services indicates that the medical system is protecting mothers and children from preventable problems.

SPM 3 - Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Increase the number of women receiving prenatal care beginning in the first trimester
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of deliveries to women who received prenatal care beginning in the first trimester of pregnancy. **Denominator:** Number of deliveries in the hospital and health centers
Data Sources and Data Issues:	Hospital Information System, Reproductive Health Information System
Significance:	Early and adequate prenatal care is vital to ensuring a healthy pregnancy. Receiving inadequate prenatal care increases the risk for complications and other adverse outcomes for both mother and baby. Early and adequate prenatal care provides the opportunity for early detection and management of complications which reduces the risk for pre-term labor and babies being born with low birth weight.

SPM 4 - Increase use of Family planning services to teenagers ages 13 to 17 years old
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To decrease teen pregnancy.
Definition:	**Unit Type:** Rate **Unit Number:** 1,000 **Numerator:** Number of unduplicated female 13-17 years old family planning method users **Denominator:** No. of female 13 to 17 years old population
Data Sources and Data Issues:	Data Source: Family planning program database. Users are those using any of the following: female sterilization, male partner sterilized, oral contraceptive, IUD, hormonal implant, hormonal injections, male or female condoms, fertility awareness method, abstinence Data issues: There's a significant challenge in collecting data in the Outer Islands. The stigma and outlook of parents in family planning services for their teenage children are part of the challenges that we have to face in this measure.
Significance:	Reducing adolescent pregnancies Pregnant adolescents are more likely to have preterm or low birth-weight babies. Babies born to adolescents have higher rates of neonatal mortality. Many adolescent girls who become pregnant have to leave school. This has long-term implications for them as individuals, their families and communities. Based on RMI's Needs assessment and strategic planning,one of RMI's priorities is decreasing teen pregnancy through providing family planning services.

SPM 5 - Increase percentage of fully immunized children ages 19 to 35 months
Population Domain(s) – Perinatal/Infant Health, Child Health, Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase immunization coverage by 4% from previous year for children 19 to 35 months old.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of 19-35 months with complete immunization **Denominator:** Number of 19-35 months children
Data Sources and Data Issues:	Data Sources: RMI National Immunization Program, WebIZ (IIS Program) Data Issues: Basic vaccine series in RMI includes: 4 DPT, 3 Polio, 3 HepB, 1 HIB, 2 MMR. Before 2016 “complete coverage” was considered to be 4 DPT, 3 Polio, 3 HepB, 1 HIB, 1 MMR. There have been substantial delays in entering data into WebIZ in the past and there are problems with the database such as duplicate records and children not known whether out of the country.
Significance:	Reduce infant and child mortality and morbidity. Prevent vaccine related diseases.

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 7 - Percent of newborns that received Congenital Hypothyroidism newborn screening
Population Domain(s) – Perinatal/Infant Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of newborn screened for congenital hypothyroidism.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of newborn screened for congenital hypothyroidism</td></tr>
<tr><td>Denominator:</td><td>Number of live births</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>MICH-32.3(Developmental) Increase the proportion of children with a diagnosed condition identified through newborn screening who have an annual assessment of services needed and received

MICH-29 Increase the proportion of young children with autism spectrum disorder (ASD) and other developmental delays who are screened, evaluated, and enrolled in special services in a timely manner</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Hospital Information System, Vital Statistics Information System</td></tr>
<tr><td>Significance:</td><td>RMI can only offer Hearing Screening for newborn which is funded under EHDI grant. During the MCH 1st Bi-Annum Workshop, the team prioritized additional newborn screening that can be done in our settings.

Congenital hypothyroidism (CH) is a condition of thyroid hormone deficiency present at birth. Approximately 1 in 4000 newborn babies has a severe deficiency of thyroid function, while even more have mild or partial degrees. If untreated for several months after birth, severe congenital hypothyroidism can lead to growth failure and permanent intellectual disability. Treatment consists of a daily dose of thyroid hormone (thyroxine) by mouth. Because the treatment is simple, effective, and inexpensive, nearly all of the developed world practices newborn screening to detect and treat congenital hypothyroidism in the first weeks of life.</td></tr>
</table>

2016-2020: SPM 8 - Percent of newborn that received congenital cytomegalovirus (CMV) screening
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Increase the percentage of newborn screened for congenital cytomegalovirus (CMV).
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of newborn screened for congenital cytomegalovirus (CMV) **Denominator:** Number of live births
Healthy People 2020 Objective:	Related to MICH-32.3(Developmental) Increase the proportion of children with a diagnosed condition identified through newborn screening who have an annual assessment of services needed and received
Data Sources and Data Issues:	Hospital Information System, Vital Statistics Information System.
Significance:	The MCH Program and Early Hearing Detection and Intervention programs advocates for the PCR- CMV Saliva test to diagnose, provide proper treatment and referrals of newborns with CMV at the right timing.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Marshall Islands

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Marshall Islands

ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To ensure that women are receiving education on the importance of well-woman visits
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of MCH women (including pregnant and postpartum) program participants who have received education on the importance of a well-women/preventive health visit in the reporting year **Denominator:** Number of MCH women (including pregnant and postpartum) program participants
Data Sources and Data Issues:	Will develop a collection tool and report to capture client and visit and service data.
Significance:	A well women visit is a way to make sure an individual is staying health. A well-woman visit is an excellent opportunity for counseling patients about maintaining a healthy lifestyle and minimizing health risks. Components of the visit may vary depending on the patients age, risk factors, and physician preference.

ESM 1.2 - Number of community health centers that provide cancer screening/referrals for women
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase to 5 the number of community health centers that provide preventive medical visits for women
Definition:	**Unit Type:** Count **Unit Number:** 5 **Numerator:** Number of health centers that provide preventive medical visits for women **Denominator:**
Data Sources and Data Issues:	RMI MOHHS Annual Report
Significance:	Through strong collaborative efforts, family planning campaigns and health education to include outreach to outlying communities in the RMI. The program will adopt the same strategy to provide preventive medical visits to women by increasing the number of community health centers that can provide basic preventive medical services to women such as family planning services packaged to include, STI & HIV screening, breast and cervical screening, BMI and BP checks, blood and glucose checks, dental screening, and health education and counseling.

ESM 1.3 - Percent of women booked for prenatal visit in first trimester
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To have a healthy pregnancy, newborn and postpartum condition of the pregnant women.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of pregnant women who had at least 4 prenatal visits, with first visit in first trimester, that delivered live birth during the reporting period **Denominator:** Number of live births during the reporting period
Data Sources and Data Issues:	Clinic/Service report, Vital Statistics, Marshall Health Information System
Significance:	Having a healthy pregnancy is one of the best ways to promote a healthy birth. Getting early and regular prenatal care improves the chances of a healthy pregnancy. With regular prenatal care women can: a. Reduce the risk of pregnancy complications. b.) Reduce the fetus's and infant's risk for complications. During prenatal care, the OBGYN doesn't only discuss the pregnancy but include post-partum conditions which will prepare the pregnant women.

ESM 1.4 - Percent of women receiving postpartum follow-up health care services within the first four to six weeks after delivery.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase or maintain the percentage of women receiving postpartum follow-up health care services within the first four to six weeks after delivery.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women receiving postpartum follow-up health care services within the first four to six weeks after delivery. **Denominator:** Weighted number of resident women population with a recent live birth. Denominator includes all respondents except those with missing, don't know and refused answers.
Data Sources and Data Issues:	Clinic/Service Report, Marshall Health information system
Significance:	Access to quality health care services during preconception, prenatal, postpartum and inter-conception phases for women of child bearing age is crucial for reducing adverse perinatal maternal health outcomes. The postpartum examination is a particularly important medical examination that is recommended to occur at about 4-6 weeks after delivering a baby. The checkup typically includes discussion of any problems that may have occurred during pregnancy, physical and biometric checks for elevated blood pressure and diabetes, discussions of postpartum depression symptoms, and other concerns. Postpartum follow-up visits are critical to assess women's post-delivery health and health risks, and greatly benefit current and future maternal and newborn health.

ESM 3.1 - Number of birthing hospitals re-designated with updated standard operating procedures
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	Update perinatal regionalization standards and designations and implement updated performance measures for hospitals in Majuro and Ebeye.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number Birthing Facilities Re-designated with standard operating procedures **Denominator:** Total Number Birthing Facilities in the state
Data Sources and Data Issues:	Endorsed SOPs
Significance:	It is imperative for the RMI to ensure all hospitals are functioning in accordance with current standards of care for both maternal and infant outcomes.

ESM 3.2 - Percent of birthing hospitals who complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	To accurately identify the neonatal and maternal level of care provided at the birthing hospitals in the RMI.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of birthing hospitals who complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually **Denominator:** Number of hospitals in the RMI
Data Sources and Data Issues:	MCH Program
Significance:	Ensuring infants are born at facilities that are equipped to meet the need of both the infant and the mother is important to improve both maternal and neonatal outcomes. The LOCATe tool is a hospital survey on obstetric and neonatal practices and services which classifies maternal and neonatal levels of care based on responses to survey questions.

ESM 3.3 - Percent of newborn babies issued newborn baby health passbook
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	To provide parents of newborn babies a passbook to monitor baby milestones, development, immunizations and clinic schedule.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of newborns issued a newborn baby health passbook annually **Denominator:** Number of births in the RMI per year
Data Sources and Data Issues:	MCH Program, Marshall Hospital Information System
Significance:	Ensure newborns are equipped with a tool to monitor their growth, development, immunization and clinic schedule.

ESM 4.1 - Percent of women provided with in-person or telephonic breastfeeding consults/support services NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of infants breastfed up to six months and increased the percent of infants exclusively breastfed.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** Number of women provided with in-person or telephonic breastfeeding consults/support services **Denominator:**
Data Sources and Data Issues:	MCH Program/Clinics. We will develop the collection tool for this ESM.
Significance:	Breastfeeding is the normative standard for infant feeding and nutrition and can result in improved infant and maternal health outcomes. Moreover, promoting and/or facilitating community activities that reinforce breastfeeding may allow for more women across the state to have access to the support they need to initiate breastfeeding and continue doing so exclusively for at least 6 months.

ESM 4.2 - Number of MCH staff and community health workers attended the Certified Lactation Counselor training. NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the percent of infants who have ever been breastfed and continues until 6 months.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of MCH Staff and community health workers who attended the Certified Lactation Counselor training. **Denominator:** Total number of MCH Staff and community health workers.
Data Sources and Data Issues:	MCH Program Report.
Significance:	Receiving health education prior and during pregnancy can motivate mothers to breastfeed their babies. But an on-call staff or community health outreach worker who takes calls anytime or makes home visits to assist with mom who needs counseling and coaching through a hard time can also motivate them to keep breastfeeding.

ESM 6.1 - The number of potential high risk screens referred to early intervention
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	That 100% of high risk screens are referred to an early intervention program and our documented.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** Percentage of high risk screens referred to early intervention/Part C **Denominator:**
Data Sources and Data Issues:	MCH Program, Marshall Health Information System
Significance:	Research shows that healthcare providers' knowledge of and referral patterns to early intervention services and other community services is quite low. It is important that we increase knowledge through academic detailing and other onsite outreach efforts. Specific attention will focus on ensuring that children identified at risk for developmental delays following a screen are actually linked with and receive the interventions recommended by the referring provider

ESM 10.1 - Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To ensure supportive programming for well adolescent visits/preventive health care.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of adolescent program participants (12-21 years) who have received education on the importance of a well adolescent/preventative visit in the reporting year **Denominator:** Number of adolescent program participants (12-21 years)
Data Sources and Data Issues:	MCH Program, Will develop a collection tool and reporting, Marshall Health Information System.
Significance:	Adolescence is an important period of development physically, psychologically, and socially. As adolescents move from childhood to adulthood, they are responsible for their health including annual preventive well visits which help to maintain a healthy lifestyle, avoid damaging behaviors, manage chronic conditions, and prevent disease.

ESM 10.2 - Percent of public middle and high schools visited to deliver pregnancy & STI prevention program
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Increase educational awareness on sexual health (teen pregnancy and STI) to adolescents ages 12-17 years old in public schools on main islands.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of public middle and high schools visited with completed delivery of pregnancy & STI prevention program **Denominator:** Number of public middle and high schools.
Data Sources and Data Issues:	MCH Program, Outreach visit reports.
Significance:	Women who become pregnant during their teens are at increased risk for medical complications, such as premature labor, and social consequences.

ESM 10.3 - HPV vaccine coverage of girls age 13 years
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	By 2020, achieving greater than or equal to 90% HPV Coverage Rate for 13 years old girls.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # females age 13 years who received 2 doses of HPV vaccine (X 100) **Denominator:** RMI Female Population aged 13 years (projected mid-year population from 2011 census)
Data Sources and Data Issues:	Query WebIZ for females 13 years of age on the last day of the measurement year (e.g. 3/31/16 for 2016) for the denominator, and select those who have record of 2 HPV doses received for the numerator.
Significance:	Cervical cancer has been the leading cause of death in the RMI over the past 10 years; the incidence and death rates from cervical cancer are among the highest in the Pacific in RMI. HPV is the cause of most cases of cervical cancer. Effective delivery of HPV vaccine to girls before the onset of sexual activity can protect the next generation of RMI women from this terrible disease

ESM 12.1 - Percent of youths with Special Health Care Need (CSHCN) enrolled in the non-medical related programs to receive services.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	Collaborate with inter-governmental agencies, business, and non-profits to provide CHSCHN with non-medical related services.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CSHCN youth registered for non-medical related services **Denominator:** Total number of CSHCN youth in the registry
Data Sources and Data Issues:	Marshall Health Information System - CSHCN Registry
Significance:	By involving business representatives on the council, it is our hope that the business community will learn more about the children and youths with special health care needs and the transition program and therefore provide them with employment opportunities.

ESM 13.2.1 - Percentage of elementary schools visited by dental program
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase the number of schools visited to educate and provide preventive measures (varnish & sealant).
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of elementary and high schools visited by dental program **Denominator:** Number of elementary and high schools
Data Sources and Data Issues:	Oral Health Services Monthly Reports
Significance:	Oral health is a vital component of overall health. Schools support student success by providing oral health care assessment, intervention, and follow-up for all children within the school setting. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits.

ESM 13.2.2 - Number of children ages 1-17 years receiving preventive dental care from a dentist.
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase preventive dental visits among children in elementary and high schools.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of children, ages 1 through 17 who had a preventive dental visit in the past year **Denominator:** The number of children ages 1-17 enrolled in elementary or high schools.
Data Sources and Data Issues:	Oral Health Services, Marshall Health Information System
Significance:	RMI MCH Program recognize the integral role of maintaining oral health across the lifespan, beginning before a child is born and continuing until the end of life. Poor oral health impacts overall health and well-being; a child's ability to learn, grow and thrive; self-esteem; employability; and overall quality of life. The "Life Course Theory" conceptual framework points to broad social, economic and environmental factors as underlying causes of inequalities in health, with oral health being no exception. The two most prevalent oral diseases, dental caries (cavities) and periodontal (gum) disease are chronic, communicable, bacterial infectious diseases that are almost entirely preventable and manageable if detected in the early stages of the disease. Dental caries is the most common, chronic disease in children, five times more common than asthma and seven times more common than hay fever. If a child develops tooth decay at an early age, they are more likely to have a lifetime of pain and suffering from poor oral health.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.2 - Percentage of pregnant women who had at least 4 prenatal visits
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To have a healthy pregnancy, newborn and post partum condition of the pregnant women.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of pregnant women who had at least 4 prenatal visits that delivered live birth during the reporting period.</td></tr>
<tr><td>Denominator:</td><td>Number of live births during the reporting period</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: MCH Program - Prenatal Clinic Visits in Majuro and Ebeye, Outer Islands Health Center</td></tr>
<tr><td>Significance:</td><td>Having a healthy pregnancy is one of the best ways to promote a healthy birth. Getting early and regular prenatal care improves the chances of a healthy pregnancy. With regular prenatal care women can: a. Reduce the risk of pregnancy complications. b.) Reduce the fetus's and infant's risk for complications. During prenatal care, the OBGYN doesn't only discuss the pregnancy but include post partum conditions which will prepare the pregnant women.</td></tr>
</table>

2016-2020: ESM 1.3 - Percent of women ages 18 thru 44 seen at outreach mobile visits
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase number of women with preventive medical visits by 5% yearly.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of 18-44 years old women that were seen during an outreach mobile visits</td></tr><tr><td>**Denominator:**</td><td>Number of 18-44 years old women in the population of the reporting year</td></tr></table>
Data Sources and Data Issues:	MCH Program - Reproductive Health Information System, EPPSO Projected Population
Significance:	Due to geographical location, limited services and health assistants capacity, there are services that we need to send a complete outreach mobile team to the Outer Islands. Currently, Outer Islands Health Centers are limited to primary health care. To provide cancer screening, immunization, dental/oral health, TB, Leprosy, NCD, and testing of STI/HIV, RMI MOHHS need to schedule the outreach to 24 Outer Islands.

2016-2020: ESM 1.4 - Number of pregnant women with dental check up
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase pregnant women that received dental check up by 5% yearly
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of pregnant women with dental check up **Denominator:** Number of pregnant women seen at the Prenatal Clinics
Data Sources and Data Issues:	MCH - Reproductive Health Information System, Dental Clinic
Significance:	Dental check during pregnancy is included in the clinical guidelines of Prenatal. Oral health care is an important component of a healthy pregnancy and providing pregnant women with oral health care, including educating them about dental caries is critical for both women's own oral health and for the future oral health of their children.

2016-2020: ESM 4.2 - Percentage of pregnant women that where given comprehensive breastfeeding counselling during prenatal visit
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase pregnant women that receive breastfeeding counselling and eventually increase infant that ever breastfed and exclusively breastfeeding up to 6 months.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** No. of pregnant women that attended the prenatal clinic given breastfeeding counselling **Denominator:** No of pregnant women that attended the prenatal clinic
Data Sources and Data Issues:	MCH Program - Prenatal Clinic
Significance:	Exclusively breastfeed for about six months gives better growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, improves normal immune response to certain vaccines, protection from allergies, and reduces probability of SIDS, low risk to non- communicable disease like diabetes, asthma, and risk factors like obesity, and better teeth development. It is also a bonding to the mother and newborn. If mothers are given proper breastfeeding counseling, they will be encouraged and will see the benefit to their children.

2016-2020: ESM 6.2 - Percentage of children diagnosed with ASD and ADHD
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Strengthen referral of children with behavioral and emotional disorder to Behavioral Health for proper diagnosis and treatment
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children diagnosed with ASD and ADHD **Denominator:** Number of children with behavioral and emotional disorder referred
Data Sources and Data Issues:	MCH Program and Behavioral Health
Significance:	Currently, there is no documented cases of ASD and ADHD before our new Psychiatrist came on board. We want to be able to diagnose and give proper attention and treatment as needed. As well as, preparing their families and support system on how to take care of a special child.

2016-2020: ESM 7.1.1 - Number of community campaign on awareness and promotion of child safety within the community.
2016-2020: NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	To be able to reach the community on awareness and promotion of child safety within the community.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of community campaign conducted **Denominator:** Number of community campaign planned (3)
Data Sources and Data Issues:	MCH Program
Significance:	Reaching community on child safety strategies will increase knowledge and lessen accident that will lead to hospitalization.

2016-2020: ESM 12.2 - Percent of adolescent that moved to adult health care
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of adolescent that receive proper referral of service from adolescent to adult health care **Denominator:** Number of adolescent that needed transition of services
Data Sources and Data Issues:	CSHCN Program
Significance:	To be able to tract and provide an appropriate service to CSHCN that transition to adult health care.

Form 11
Other State Data

State: Marshall Islands

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Marshall Islands

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Monthly	0		
2) Vital Records Death	Yes	Yes	Monthly	0	No	
3) Medicaid	No	No	Never	NA	No	
4) WIC	No	No	Never	NA	No	
5) Newborn Bloodspot Screening	No	No	Never	NA	No	
6) Newborn Hearing Screening	Yes	Yes	Monthly	0	No	
7) Hospital Discharge	Yes	Yes	Monthly	0	No	
8) PRAMS or PRAMS-like	No	No	Never	NA	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	**1) Vital Records Birth**
	Field Note: Vital Records Information System
Data Source Name:	**2) Vital Records Death**
	Field Note: Vital Records Information System
Data Source Name:	**3) Medicaid**
	Field Note: RMI don't have Medicaid.
Data Source Name:	**4) WIC**
	Field Note: RMI don't have WIC.
Data Source Name:	**5) Newborn Bloodspot Screening**
	Field Note: RMI don't have newborn bloodspot screening.